SB 480/Health Care Options Project

CAL CARE

A SINGLE PAYER HEALTH PLAN FOR CALIFORNIA

March 31, 2002

Principal Authors:

Judy Spelman, RN

Health Care for All – California

Contact:
Judy Spelman, R.N.
P.O. Box 1204
Point Reyes Station, Ca. 94956
Phone and Fax: (415) 663-1740
Email: jspelman@svn.net

DEDICATION

"Of all forms of inequity, injustice in health care is the most shocking and the most inhumane"

Martin Luther King, Jr.

Cal Care is dedicated to:

Martin Luther King, Jr., who struggled for justice,

Margot Wiesinger Smith, who continues the struggle

and

U.S. Congresswoman Hilda Solis,

whose legislation made this study possible

ACKNOWLEDGMENTS

Cal Care was written with the help of people from around the state, the nation and abroad. It could not have been written without their expert, gracious assistance. Participation development of this proposal in no way implies endorsement of its content.

The following people performed independent research and co-authored sections: Linda Remy, “Quality First;” Margot W. Smith, “Health Planning;” Alan Sager, “Pharmaceutical Purchasing Policy;” Stan Price and Ed Howard, “Obstacles to Implementation of a Single Payer System;” Beatriz Solis, “Cultural and Linguistic Considerations;” Karyn Gill, “Governance;” Miriam Schocken and Joel Johnson, “Transitions;” Lenny Goldberg, “Cal Care Taxes;” Ignatius Bau and Joel Johnson, “Eligibility and Enrollment;” Charlene Harrington, “Long Term Care;” Richard Schiller, "Complementary and Alternative Care;” Laura Remson Mitchell, “Disability Benefits;” Norman Bobes, “Physician Cost Constraints;” Walter Wieners, "Information Technology;" and Lynn Blair Wood, "Dental Benefits."

The following people consulted in their areas of expertise: Edie Rasell (Economic Policy Institute, finance); Katie Levit (Director, National Health Statistics Group, CMS, finance); Kimberley Bott (Assembly Revenue and Taxation Comm., tax, risk); Martin Helmke (Senate Revenue and Taxation Comm., tax, risk); Seren Taylor (Republican Fiscal Comm., finance), John Miller (Senate Health and Human Services Committee, tobacco taxation); Paul Speigel, France Ministry of Health, (France health care system) Jennie Chinn Hansen (On Lok Senior Center, long term care); Peter Fitzgerald (Program for the All-Inclusive Care for the Elderly, PACE, long term care); Sandra Murbach (National Acquisition Center, purchasing policies); Joe Kime (Veteran’s Administration, purchasing policies); Mark Wynn and Ann Meadow (Center for Medicare and Medicaid Services, DME purchasing policies); Senior Officials at the Ontario, Canada Ministry of Health (health planning, reimbursement, utilization constraints, health information partnerships, medical malpractice); Nan Baines (Ontario Health Intelligence Unit, information technology and management); Gabrielle Lessard (National Immigration Law Center, eligibility and enrollment); senior physicians and managers at Kaiser Permanente (selected features of the proposal); John Mott-Smith (Director, Elections Divisions of California, governance); Margot W. Smith (HCA, View from Abroad, Australia and Germany); Hubert J. Morel-Seytoux (HCA, View from Abroad, France); Dan Carson (Legislative Analyst Office, health fund); Karen Blackman, Lou Mone, Sally Bowie, Randy Paulsen, Ann Eldridge and Randall Hagar (NAMI-CA, mental health parity); Ramon Castellblanch (Quinnipiac University, long term care); Jonathan Gruber (Massachusetts Institute of Technology, tax policy); Joyce Mills (nurse staff ratios); Doris Nelson (HCA, quality, governance); Harry Swope (Council for Homeopathic Certification, naturopathy); Anna Thorn (governance, campaign finance reform); Jennifer Dunham (HCA, View from Abroad - Canada); Peter Abbott (governance); Fred Davis (Maine single payer legislation, ERISA); Allan Beek (HCA, legal); Sally Acosta, Michelle Hurlbutt RDH, Marsha Larrabee, RDH, Bob Isman, DDS, (dental benefits); Linda Roberts (HCA, public-private partnerships, unions); Paul Krehbiel (HCA, unions); Jerry Lubin (unions); Hastings Law School (ERISA pre-emption); Linda Rudolph, MD, Kathy Dervin, Glenn Shor, PhD, Paul Blanc, MD, UCSF and Bob Harrison MD, UCSF (Workers’ Compensation); managers and analysts at the California Board of Equalization (alcohol taxation); and John Metz and Irwin Hoff (consumer advocacy).

The following people reviewed parts of the proposal and offered advice: Stephen F. Tarzynski MD, Marc Snyder MD, Jeffrey Schneider MD, Barbara Storey, Steve Schear, Garold Faber, Dan Hodges, and Linda Remy.

Thanks to Health Care Options Project staff, Genie Chough, David Maxwell-Jolly, Peg Gerould, and Tala York; modelers, John Sheils, Randy Haught and Claudia Williams; and Project Manager Gary Claxton, who offered practical support and encouragement.

Technical support was provided by Dan Hodges, Irwin Hoff, John Metz, Joel Johnson, Richard Schiller, Jennifer Dunham, Susan Snow, Carrie Walsh, Peter Conn, George Delury, and Gerry Hunt.

Special thanks to Wayne O. Veatch, whose patience and legal savvy bore fruit; The California Endowment for generous support of the HCOP authors; John Miller, California Senate Health and Human Services Committee, for wise guidance from start to finish; Peter Hansel, Senate Office of Research, who stepped in at the right moment to ensure that the study would happen; Dan Hodges, Chair, Health Care for All-California, for expert editing and gentle critique; Pat Kendall, RN and Vincent Reed, RN, for granting a leave of absence from Kaiser San Rafael Emergency Room; and Linda Remy, whose help and encouragement went beyond the call of duty.

TABLE OF CONTENTS

CAL CARE APPENDICES

EXECUTIVE SUMMARY

Cal Care is presented to the people of California by Health Care for All-California, a statewide organization that advocates for and educates the public about single payer health care.

Despite California's great wealth and reform efforts, the health care system faces very serious problems. The number of Californians without health insurance hovers around seven million. The quality of care received by all Californians is deficient by state, national and international standards. Health outcomes vary by income and race. Growth in health care spending far exceeds growth in the gross domestic product. Once-secure coverage for seniors is vulnerable, as health maintenance organizations exit the market. Poor reimbursement limits the number of providers willing to care for Medicaid and Medicare patients. Rural Californians and others in unprofitable markets have trouble accessing care. Denial of care and limitations on choice of provider are common. Benefit packages are shrinking. 10 million Californians have no prescription drug benefit. Premiums, co-pays and deductibles are rising. Public health and safety net solvency is threatened. Physician discontent and nurse shortages are widespread.

Cal Care is a comprehensive health system reform, based on a "single payer" model. Single payer combines administrative efficiency and sound financing to create a universal-coverage health care system that provides high quality care and controls costs. The Lewin Group Report, commissioned by the state of California for the Health Care Options Project, demonstrates that Cal Care covers all Californians for less than we now spend on health care. (See the table on page 4.)

Under Cal Care, the state of California establishes a health insurance plan that covers all Californians. The plan replaces all other insurance plans, public and private. It is financed by a tax on payroll and non-payroll income, by federal, state and county monies currently committed

to health care and by modest increases in sales, alcohol and tobacco taxes. Taxes replace all insurance premiums, co-pays, deductibles and other out-of-pocket expenses. For most Californians and most employers who now provide health benefits, the tax will be less than they now spend on health care, according to the Lewin Report.

Costs are controlled through system efficiency, global budgets, state purchasing discounts, and linkage of growth in health spending to the growth of population and California Gross Domestic Product.

Quality of care is improved by the shift of resources from administration to health care, enhanced funding for public health, emphasis on primary and preventive care, equitable distribution of resources, budget formulae weighted to correct health outcome deficiencies, statewide health planning in which all key stakeholders participate, state support of health research, linkage of research to health system goals, balanced deployment of health technologies, return of medical decision-making to health care practitioners without government or insurance company interference, implementation of safe staffing ratios and by consumer advocates in each county.

Everyone can choose his or her own doctor. All providers may participate.

Single payer is used successfully around the world. This proposal demonstrates how single payer could be adapted to California's unique needs and resources.

INTRODUCTION TO CAL CARE

We open the proposal with a declaration of the principles underlying the reform. We follow with a segment entitled "Quality First," which documents the nature and scope of the problems facing our health care system. We then present our approach to solving the problems. We describe the kind of health care planning and delivery system that underlie high quality care. We

present the benefits every California resident will receive, the eligibility requirements and practical aspects of enrollment. We go on to discuss the finance, cost control and governance reforms needed to sustain a universal health system. We conclude with an analysis of impacts on key stakeholders, the transition to Cal Care and the obstacles to a reform of this magnitude. We provide charts summarizing key findings of the Lewin Group and AZA Consultants, who performed the econometric micro-simulation modeling and the quality analyses for the SB 480/Health Care Options Project. We include four expanded benefit packages of special interest.

PRINCIPLES UNDERLYING CAL CARE

- All people are created equal and should have an equal opportunity to achieve their best possible state of health.
- Providing high quality care is as important as providing universal coverage.
- The health system must harness advanced technologies to meet health needs.
- The initiative, creativity and entrepreneurial spirit of the market system can play an important part in a single payer system.
- Public-private partnerships for health must assure that workers receive prevailing wages, benefits and working conditions.
- The system will be built on the foundation of existing institutions whenever possible.
- There are lessons to be learned from nations with single payer national health plans.
- Governance will emphasize local autonomy and initiative side-by-side with system-wide planning and budgetary oversight.
- Goals of the Cal Care single payer system are universal coverage based on California residency, high quality health care for all, administrative efficiency, fiscal soundness, provider, health worker and consumer satisfaction, public and business confidence and participation in the system.

Changes in State Wide Health Spending Under Cal Care in 2002

		Amount in Millions
Current Health Spending[a/]		$151,776
Increases in Utilization		
Utilization Change for Uninsured		$3,465
Change for "Underinsured"		$2,796
Prescription Drugs	$174	
Dental Care	$1,147	
Other	$1,475	
Elimination of Cost Sharing		$8,286
Long-term Care		$2,606
Nursing Home	$1,609	
Home Health	$997	
Alternative Medicine		$449
Spending Offsets		
Increase Primary Care Emphasis		**(-$3,198)**
Bulk Purchasing		**(-$4,032)**
Prescription Drugs	$3,641	
Durable Medical Equipment	$391	
Administrative Costs		**(-$14,080)**
Insurer Administration	$6,650	
Hospital Administration	$2,270	
Physician Administration	$5,160	
Total Before Global Budget Cap		
Provider Payment Reductions		N/A
Net Change in Spending with Budget Cap		
Net Change		**(-$3,708)**

[a/]Excludes public health.

N/A - Not required to stay within global budget cap.

Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

QUALITY FIRST

The World Health Organization (WHO) recently ranked the quality of health care provided in 191 nations. The United States (U.S.) ranked 37th., below Saudi Arabia, Morocco, Oman and every industrialized nation in the world. Responsible health reform must address quality and coverage with equal fervor.[1]

CALIFORNIA'S STORY

California ranks 22nd. out of 50 states in per capita spending on health care.[2] Rates of uninsurance for California congressional districts ranges from 13%-44%.[3] Only three states have higher uninsured rates (Arizona, Louisiana and New Mexico). There are racial disparities among the uninsured.[4] In California, 13% are non-Hispanic white children, 30% are Hispanic Americans, 19% are Asian Americans, and 18% are African Americans. Two million children are uninsured.

WHO ranks U.S. physician availability below Uruguay, Azerbaijan, Kazakhstan, Armenia, Uzbekistan, and most European nations.[1] California ranks in the second quintile for physicians per U.S. population.[2] We rank in the lowest decile for many other important infrastructure indicators (Table 1, Appendix A). For example, our RN to population ratio is the worst in the nation. Other resources are distributed inequitably:

- The number of primary care physicians per 100,000 persons is 146 in Marin County, 86 in Contra Costa County and 60 in Kern County.[5]
- 50 % of California hospitals discharging children have no licensed pediatric beds.[6]
- Between 1983 and 1998, the number of California hospitals with emergency rooms dropped 13%. In 1983, Alameda County had 20 emergency rooms; in 1998 it had 10. Three counties have no emergency rooms.[6]
- Almost all of California's Central Valley and large portions of northern California lack immediate access to high-level trauma centers.[7]

- The OSHPD California Hospital Outcomes Project found wide variation in hospital-based patient outcomes.[8] [9]

- Between 1983 and 1998, the number of California hospitals discharging patients dropped 13%. The number discharging children age 30 days to 14 years dropped 30%.[6]

- Los Angeles County residents over age 65 have unlimited drug coverage if they belong to Kaiser Senior Advantage, whereas Kaiser subscribers in Kings, Fresno and Marin counties have an annual maximum drug coverage of $1600. Co-pays for Kaiser Medicare Senior Advantage patients are $12.50. Co-pays for PacifiCare/Secure Horizons subscribers in Napa are $5; co-pays in Riverside are $10.[10]

Other important ways in which California's health care resources are inequitably distributed are provided in Table 2, Appendix A.

PRESCRIPTION DRUG COVERAGE PROBLEMS

The U.S. joins nations such as Chile, Cuba and Ghana in failing to maintain national records on the percent of the population with access to "essential drugs," as defined by WHO. However, what we do know is not comforting.

Of the $20.8 billion dollar increase in outpatient spending on drugs from 1999-2000, 36% results from a shift in the mix of drugs dispensed from lower to higher-priced medicines.[11] Medicare-authorized payments in California for 24 leading drugs were $887 million more than wholesale prices available to physicians and suppliers through the Federal Supply Schedule.[12] California has never taken full advantage of many discount drug opportunities made available by the federal government. The net effect of these policies is to decrease the number people who can afford to fill prescriptions and to increase avoidable illness and suffering.

STEWARDSHIP AND ACCOUNTABILITY PROBLEMS

Absence of overall stewardship and accountability has led to widespread fraud and misuse of funds that divert money away from health care services.

- Fraudulent billing for services not provided and "upcoded" claims total billions of dollars according to the U.S. Office of the Inspector General. California providers figure prominently on the list of fraudulent billers.[13]

- The California State Auditor found that lengthy delays and poor monitoring by regulatory agencies weakened consumer protection.[14]

- In 1999, for-profit managed care organizations earned investment income in excess of $100 million on Medicare funds, an illegal practice. Income on Medicare funds is limited to use for benefits or finance arrangements. Otherwise, it must be returned to Medicare.[15]

- In the biggest health care fraud in history, TAP Pharmaceutical Products pleaded guilty to criminal violations of the Prescription Drug Marketing Act. The president, current and former managers were charged with conspiring to pay kickbacks to customers and to defraud Medicaid and Medicare. They paid $875 million in penalties.[16]

- Between 1997-2000, consultant KPMG cost recommendations led to criminal and civil fraud charges against Columbia/HCA. Two executives were convicted of conspiracy and criminal and civil fraud. They paid $750 in partial settlement of the civil fraud. The federal Health Care Finance Administration renewed contracts with KPMG after they knew the firm was engaged in fraud.[17]

- Non-profit hospitals are expected to provide benefits in return for tax exemption. Between 41% and 71% of non-profit hospitals provided less charity care than the value of their tax exemption.[18] Non-profit hospitals with the greatest ability to finance charity care tend to have the lowest rates of charity care. Non-profit non-teaching hospitals provide 55% of total hospital days but only 27% of charity care.

HEALTH OUTCOMES PROBLEMS

In 2001, no HMO rated by California consumers received an excellent rating on any dimension of quality or service.[19] A more formal indicator of consumer well-being is population-based mortality. The disability-adjusted life expectancy (DALE) -- years to be lived in "full health" -- in the U.S. is 70 years. This is 24$^{th.}$ in the world, below every European nation and Israel.[1] Nations with a higher percentage of males living to 65 include Cuba, Costa Rica, Canada, and Australia.

There is mounting evidence that our health care system fails to provide high quality care. For example:

- The Institute of Medicine estimated that 750,000 to greater than one million adverse hospital events occur annually. From 44,000 to 98,000 people die annually at least in part because of medical error.[20] [21]

- Hospitalized children are exposed to three times more potential adverse drug events than adults.[22]

- Children have increasingly higher rates of complications, non-routine dispositions and longer hospital stays.[6]

- Independent studies find that some hospitals have worse than expected outcomes.[8] [9] [23] [24]

- Studies show associations between hospital financial characteristics and quality of care.[25] [26] [27]

- Decreasing RN staff ratios increase complications.[28] [29] [30] [31] Just one hour more of nursing care than today's average of nursing hours would result in 10% fewer urinary tract infections and 8% less pneumonia.[32] Adequate RN staffing is consistently and strongly associated with 2-25% reduction in adverse patient outcomes.[32] [33] [34]

- Inadequate staffing for other hospital workers also impacts outcomes. For example, mortality rates decrease as staffing of residents, pharmacists and medical technologists increases.[35] [36]

This is a snapshot of the problems we face. Improving the quality of care must be a health reform priority.

HEALTH CARE PLANNING AND DELIVERY

Health care planning in our current system is fragmented. Virtually no public health programs reach the entire population. Fragmented planning and segregated delivery of "public" and "private" care contribute to poor population health outcomes. Implementation of a statewide health care system makes it possible to perform comprehensive planning, set system wide care standards, implement quality of care initiatives and establish public health programs that reach all Californians.

RECOMMENDATIONS

1. Health planning must be an integrated statewide process.
2. The Office of State Health Planning and Development (OSHPD) should assume the lead role in health planning at the state level.
3. OSHPD should be part of the State Health Agency, the consolidated state health care administrative agency.
4. Regional and local planning should be performed by consortiums of the County Health Officer and representatives of key health system stakeholders.
5. Ongoing communication and cooperation between state, regional and local planners is essential.

GOALS

1. Implementation of universal coverage.
2. Equitable distribution of resources, including advanced health technology.
3. Delivery of uniformly high quality, culturally and linguistically sensitive care.
4. Measurable improvement in health outcomes.
5. Measurable decrease in medical errors.
6. Provider, consumer and health worker satisfaction demonstrated in measurable terms.
7. Business participation and confidence in the health care system.
8. Responsible budgeting with enforceable spending ceilings.

STEPS TO IMPLEMENT STATEWIDE PLANNING

1. Define goals in measurable terms.
2. Delineate planning regions.
3. Constitute regional planning boards.
4. Develop a process to establish stakeholder representation.
5. Establish communication and coordination among regional and state planners.
6. Identify new systems needed to implement goals.
7. Consolidate new and existing systems.
8. Develop health services budget recommendations.
9. Evaluate system performance.
10. Plan and budget for needed improvements.

HIGHLIGHTS OF HEALTH PLANNING AND DELIVERY

We highlight selected Cal Care health delivery and planning policies here and provide more information in the Appendices.

- Spending per region will be based on formulae weighted for per capita income, population demographics, service and outcome deficiencies.
- Planning bodies will include representatives of key health system stakeholders.
- Measurable and quantifiable standards of care will be established and system performance monitored.
- Population-based health strategies and programs that encourage healthful individual behaviors will be included in the benefit package with finance incentives to assure broad implementation. Incentives include: train primary care physicians in population-based health, improve primary care salaries to attract providers, reimburse advertising and outreach for these programs, evaluate the health status of Californians, link research to public health goals and adjust budgets as needed to correct deficiencies.
- Every Californian should have a primary care provider.
- Every California resident should be enrolled in Cal Care. Many means will be employed to reach this goal including demonstration enrollment projects, multi-language community outreach prior to initiation of Cal Care services and beyond, simplified enrollment, automatic

enrollment of newborns and those attaining US citizenship while in California, enrollment at all points of contact with health care system, on line enrollment, emergency room referrals to primary care providers, and en masse enrollment for existing groups such as Medicare and Medi-Cal recipients and members of integrated health care systems.

- Disability Task Force established to identify unmet special needs, make programmatic recommendations and identify representatives to serve on regional planning entities.
- Workers' Compensation Task Force to recommend a reform plan and a process for its integration into Cal Care.
- Resource allocation will reflect specific, measurable health care needs.
- Health indicators developed to allow comparisons of health outcomes between counties.
- Distribution of provider and hospital services tracked to identify inequities.
- Financial incentives to encourage equitable distribution of providers.
- Adequacy of access monitored.
- Referral and transportation systems for persons living in rural or remote areas.
- Easy public access to non-confidential provider, facility outcome and performance data.
- Public-private partnerships of universities and private research groups link research and health planning.
- Systems for monitoring and resolving consumer and provider complaints established.
- County Advocates play key role advocating for consumer interests.
- Hospital nurse staffing ratios implemented using the process outlined in AB 394 (Kuehl-D., Los Angeles). Full text of the bill and a discussion of the staff ratio issue are found in Appendix A.
- Safe staffing principles applied to licensed professionals in all health care settings.
- Nursing shortage addressed through finance support for education, salary improvements for specialty skills, creation of bedside-nursing career ladder and on-site child care.

SELECTED HEALTH PLANNING AND DELIVERY PROGRAMS

COORDINATED, EQUITABLE DEPLOYMENT OF ADVANCED INFORMATION TECHNOLOGY

Missing in the health technology revolution is an equitable application of its many benefits. There are virtually no statewide, population-based programs that link technology and broad

health system goals in today's fragmented system. In contrast, an integrated system where statewide health planning is performed offers the possibility of harnessing the great technologies to meet population-based health needs. Under Cal Care a special office of the State Health Agency will oversee and offer financial support for the development and equitable deployment of advanced health technology. Such state support offers the opportunity for a focused explosion of innovation.

U.S. and California health care organizations are not well prepared to adopt information technology effectively. Health care is largely a decentralized industry populated by diverse and often competing organizations with different motives, resources and incentives. Fiscal constraints hinder the industry's ability to make major investments in information systems and applications.[37] Expanded utilization of information systems and the adaptation of electronic communication standards are a critical component in the successful operation of a single payer model. The Office of Technology and Research will identify and implement needed organizational changes.

A single payer system will benefit from the work of the International Medical Informatics Association (IMIA), Switzerland; the findings at the National Coordination Office for Information Technology Research and Development, Arlington, VA; and communications standards groups, such as Health Level Seven. Also of value will be the California Cooperative Healthcare Reporting Initiative, a collaborative effort (funded by the California Health Foundation) among health plans, providers and purchasers, whose mission is to: "collect and report standardized, reliable health plan and provider organization performance data and promote the use of accurate and comparable quality measures within healthcare." Work by the California Information Exchange, CALINX, will have application in a single payer system. (CALINX is a

broad-based effort among California businesses, physicians, health plans, hospitals, and health care systems that collaborate on standards and cooperate on implementation.)

Some consensus has developed in California regarding information system priorities for the health care system. Those systems include the following important elements:

- An electronic data interchange (EDI) capability for sending and receiving data among geographically dispersed locations.
- A longitudinal electronic medical record (EMR) to capture treatment, costs and quality at the point of care.
- Real-time feedback mechanisms to facilitate continuous process improvement at the provider level.

CULTURAL AND LINGUISTIC CONSIDERATIONS

A culturally competent system of care has the potential to improve outcomes, efficiency and cost effectiveness. Cal Care uses multiple strategies to promote culturally sensitive care. Our comprehensive recommendations, included in Appendix A under "Strategies for a Culturally Competent System," are summarized here.

- Adoption of standards for culturally and linguistically appropriate services set forth by the Los Angeles working group of community and legal advocates, health providers and health plans assembled by the County Board of Supervisors in October 1999.
- Implementation of policy recommendations for the delivery of culturally competent care made by the state Department of Health Services and the Department of Managed Care.[38]
- Adoption of the 14 standards developed by the national Office of Minority Health in conjunction with Resources for Cross-Cultural Health Care and the Center for Advancement of Health for "Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcome-Focused Research Agenda" (CLAS standards). These standards include cultural competency training, availability of interpreters and translation of written informing materials, including signage.
- Implementation of the "Guidance Memorandum" issued by the federal Office of Civil Rights in October 2000, which clarified expectations regarding provision of language appropriate services for Limited English Proficient (LEP) patients.

"MEDICAL HOME"/PRIMARY CARE SYSTEM

Every Californian will have the opportunity to select a personal medical provider or, as some say, a "medical home." This practitioner will provide and oversee general health care needs. For adults this will be a primary care physician, a nurse practitioner or a physician assistant. For children this will be a pediatrician, pediatric nurse practitioner or physician assistant. In addition to their primary care practitioner, women may see gynecologists and obstetricians without referral. Primary care providers may refer their patients to specialists without restriction. Specialists must indicate the source of a referral when making a claim for payment. In some cases a primary care provider and a patient may determine that a specialist should be the primary provider. This is an acceptable arrangement under Cal Care. The limitation of such an arrangement is that one's health needs are not limited to a special condition one may have. Specialists tend to focus on excellence in their field and may not be well trained to meet broad health care needs. Ideally, a primary provider will remain involved.

ESTABLISHING USUAL SOURCE OF CARE

Establishing usual sources of care for all Californians will be a challenge. Most integrated systems have programs to match patients and providers. The fee-for-service sector must create similar programs.

Long before the initiation of services under Cal Care, County Health Agencies will begin working with providers and community leaders to develop provider profiles and train personnel to work in multiple languages with individuals seeking a medical home. At all points of entry into the health care system and at the time of enrollment people will be screened to determine if they have a usual source of care. If they do not, the process of establishing one will begin. Information systems will be implemented to track enrollment and source of care data to identify areas where outreach needs improvement. All written materials will be provided in multiple

languages. Provider assignment programs will be on-going and offer opportunities for public-private partnerships.

The medical home model accomplishes five important goals:

1. Assures that every Californian receives basic medical services from a practitioner who is competent to provide and oversee general health care needs.
2. Assures that care rendered by multiple providers will be coordinated.
3. Assists patients in identifying appropriate specialists and the need for specialty care.
4. Saves money by limiting inappropriate use of specialists.
5. Minimizes the need for emergency departments to provide non-emergent care.

EMERGENCY ROOM REFERRAL SYSTEM

County Health Agencies will work with local emergency rooms to develop a referral system for people who present with non-emergent problems. "Same-day" appointments with appropriate practitioners will be made. Emergency rooms will screen all patients to determine if they have a usual source of care and will begin the process of establishing one, when appropriate.

MEETING THE NEEDS OF PEOPLE WITH DISABILITIES

People with disabilities are often underserved. While many have insurance, far too often their special needs remain unmet. This causes pain and functional limitation and diminishes the likelihood that a person can reach his or her full potential. All Californians stand to benefit from a system that provides appropriate care to people with disabilities. We are all an accident or a diagnosis away from becoming disabled. A Disability Task Force will be established to help represent people with disabilities, to send representatives to regional planning consortiums, to identify unmet needs and to develop programs to correct them. Lists of priority benefits enumerated by disability activists can be found at the end of this proposal.

NURSING SHORTAGE

The shortage of nurses is scientifically documented, a daily challenge for administrators in charge of staffing and hiring, frustrating, even dangerous for patients and a daily dilemma for nurses. Cal Care addresses the shortage in many ways including:

- **Funding for Education.** During the transition the need for education finance support will be assessed on a regional basis and program and budget recommendations made.

- **Creation of Bedside-Nursing Career Ladder.** Unlike other careers where opportunities for financial advancement imcrease as experience is gained, skills improve and greater responsibility is assumed, for a bedside-nurse the salary differential at the start and at the end of a career is minimal. The salary differential for specialty nurses, such an emergency, intensive care and neo-natal ICU, is non-existent. For nursing supervisors pay differential is insignificant. Cal Care budgets will include risk adjustments to correct these problems.

- **Implementation of Safe Staffing Ratios.** AB 394 (Kuehl-D., Los Angeles) is a good starting place to address unsafe staffing conditions shown to be present in many California health care facilities. Budgets will include risk adjustments for ongoing safety monitoring and implementation of safe staffing.

- **On-Site Hospital Child Care.** The availability of high quality, on-site child care will attract people to most professions. This is especially the case in a female-dominated profession. During the transition, demonstration on-site health facility day care projects will be initiated to identify and implement the best approaches, including cost-effective approaches.

ELIGIBILITY

TARGET POPULATIONS/MECHANISMS FOR EXPANDING COVERAGE

The mechanism for expanding coverage is provision of a uniform insurance plan for all Californians funded by tax revenues. The target population is all California residents.

ELIGIBILITY REQUIREMENTS

- Physical presence in California and one of the following:
- Proof of residency for 3 months with intent to remain indefinitely. There will be a variety of ways to prove residence. The following are a non-exhaustive list of ways to prove residency and establish intent to remain: utility bills, proof of school enrollment, third party affidavits (no payment stipulation permitted), proof of eligibility under federal statute, driver's license, employment records, leases, rental payment receipts, mortgage payments, bank activity documents, sales receipts of purchases in California, and proof of voter registration. Should a pattern of abuse emerge, this liberal policy will be constricted.
- Eligibility is assumed at the point of service. This will trigger an eligibility review.
- Non-immigrant residents in California for temporary employment, with proof of employment and payment of health tax, pro-rated when appropriate.
- Californians temporarily out of state for up to 90 days.
- Californians employed out of state who pay the California health tax and/or whose employers pay the health tax.
- For long-term care, two years of California residency immediately prior to seeking long term care, during which time all required health tax payments must have been made.
- Federal workers living in California (whose Cal Care payments we assume will be made by their employers in lieu of making FEHBP payments).

We include a short durational residency requirement of 3 months. There is little benefit to withholding services from a bona fide new resident. When services are withheld people use the emergency room for basic care or they postpone care until they are very ill. Both cost more than providing regular medical care. Cal Care will allow private insurers to offer short-term policies

to those awaiting eligibility. If these approaches induce migration for the purpose of seeking care, they will be terminated until a national health plan is in place.

SPECIAL CASES

Cal Care will have an arbitration process and will utilize some of the guidelines employed by the University of California to deal with the many special circumstances that arise. For example:

- Unmarried minors have residency status of the parent with whom they last resided.
- Act of the minor or the minor's guardian cannot change residence of unmarried, unemancipated minors as long as the parents are living.
- If a minor's parents are deceased and a legal guardian has not been appointed, or if a minor has been emancipated by court order, the minor may establish one's own residency.
- California visitors will be presumed eligible at the point of service. They will be billed for services.
- Californians out of state for greater than 90 days may be allowed to pay the health tax and retain benefits under certain circumstances. However, they will be required to return to California for ongoing health treatments, at the discretion of the County Health Officer in their county of residence.

See Appendix D for further documentation in support of the Cal Care eligibility policy.

IMMIGRATION

California employers, on a regular or intermittent basis, employ most documented and undocumented immigrants. Like all others residing in California, immigrants pay taxes in a variety of ways including income, sales and license, property taxes, and user fees. One estimate is that immigrant households paid $133 billion in taxes in 1997 and that a typical immigrant and his descendents will pay $80,000 more in taxes than they will receive in local, state and federal benefits over their lifetimes.[39] A recent Institute of Medicine study showed that immigrants make up just 6% of the uninsured population.[40]

Under Cal Care, permanent California immigrant residents, documented and undocumented, will be as eligible for benefits. Temporary immigrant residents here for employment will be

eligible during periods of employment. They will pay the health tax through payroll deduction like all other employees.

Ultimately, it will cost California more to exclude immigrants than to include them. People without insurance go to emergency rooms for basic care. Often they delay care until they are very ill and need hospitalization and expensive diagnostic tests. Late care, emergency and hospital care are much more expensive than early, preventive care.

Although the Immigration and Naturalization Service (INS) has said it will not limit admissibility because of need for health services,[41] some immigrants are anxious and confused about possible repercussions should they seek or enroll for health services. To deal with these concerns and to conform to the Federal Privacy Act, Cal Care will prohibit sharing of enrollment and service information with the INS and will use unique, non-social security identifiers.

ENROLLMENT

Our goal is to enroll every California resident in Cal Care. This will require a high degree of involvement and cooperation among state and local health agencies, community organizations, regional planners, the California Medical and Nursing Associations, schools, hospitals, clinics and others. Enrollment is a continuing process that will start during the transition period. Demonstration projects will help identify effective enrollment techniques. People will be able to enroll at multiple sites, including internet sites. Those in Medi-Cal, Medicare, Healthy Families, HMOs, and other group programs will be enrolled in the system *en masse*. Newborns and those attaining US citizenship while residing in California will be enrolled automatically. Community, school and media outreach programs will inform people about how to enroll. Provider profiles will be developed to inform the choice of provider. Teams with multi-language capabilities will assist in the local enrollment process.

Enrollment, maintenance and update of records are areas rich in possibilities for public-private partnerships. Early enrollment will assist planners and providers to allocate resources. Other aspects of the enrollment process are discussed under "Health Care Planning and Delivery."

BENEFITS

Under Cal Care the benefit package is established and modified through a coordinated state and regional planning process. For most Californians the Cal Care benefits far exceed those they have now. Cal Care guarantees that no Californian will lose benefits they currently enjoy.

CAL CARE BENEFITS

- The Kaiser Permanente large group market standard benefit packages, including the drug formulary.
- Additional benefits for which some Californians are now eligible under Medicaid and Medicare, such as certain long term care services.
- Expanded benefits such as alternative and complementary care, dental care (preventive and emergency care) mental health parity and additional disability benefits.
- Partial coverage for long term care for those not now covered after two years of residency (all nursing home costs are covered, except for room and board).

The alternative care benefits are presented below. Other expanded benefit packages and the long term care package are included at the end of the proposal.

KAISER AND FEDERAL BENEFITS

Generally, Kaiser and Federal benefit include:

- Office-based and hospital based outpatient medical, surgical and mental health services, including preventive and health maintenance care, prescribed and delivered by licensed providers.
- Inpatient medical, surgical and mental health services prescribed and delivered by licensed providers.
- Pharmaceuticals and DME from the system formularies. (Cal Care may make adjustments to the Kaiser formulary as purchasing policies develop.)
- Diagnostic tests and treatments prescribed by licensed providers.
- Podiatry services.
- Vision care services and products.

- Dental services, primarily preventive and emergency care.
- In-home care for chronic and acute illness.
- Emergency care.
- Hospice care.
- Transportation Services, emergency and non-emergency, in some cases.
- Translation Services including multiple spoken languages, services for LEP, deaf and blind.
- Skilled nursing care, following acute hospitalization.
- Limited long term care.
- Behavioral change interventions, including stress management, weight control, nutrition counseling, substance abuse prevention, exercise classes and counseling and environmental awareness (toxic exposure prevention).

ALTERNATIVE AND COMPLEMENTARY BENEFITS

Alternative and complementary benefits include:

- Chiropractic
- Acupuncture
- Homeopathy
- Nutrition Services
- Bio Feedback
- Herbal Remedies
- Meditation Training
- Naturopathy
- Other alternative therapies

In conjunction with the National Institutes of Health's Office of Complementary and Alternative Medicine, Cal Care will assure safety and efficacy of alternative modalities before

they are included the benefit package. Alternative practitioners who wish to participate must be licensed. Where licensing doesn't exist, it will be established by the State Health Agency.

A thought-provoking policy question is whether an integrated system should be allowed to offer benefits over and above the standard Cal Care package if it stays within its global budget ceiling. One can argue that retaining this element of competition favors consumers who would pay no more for the added benefits. For policy makers there would be something to learn about how benefits were expanded and budget limits maintained. On the other hand, would this create a tiered system of care, something Cal Care is philosophically opposed to? Would it put pressure on the system to provide benefits when the system may not be able to afford them? It is too early to answer these questions. They merit further discussion.

FINANCE

Cal Care establishes a system for funding universal health care, allocating resources, stabilizing costs and controlling growth in spending. The finance system has four basic elements: a health fund, tax-based funding, cost controls and risk adjustment. The finance system is administered jointly by the State Health Agency and the State Health Fund. The State Health Agency has the authority to expend funds and delegate expenditure authority. The State Health Fund receives all monies that finance health care.

STATE HEALTH FUND

The State Health Fund is established by legislation as a Special Fund to receive and hold funds, make payments, determine the health tax rates, and make regulations related to this authority. Key elements of the legislation are:

- **Continuous appropriation -- monies carry over from year to year**. Annual appropriation of funds improves public accountability through legislative review. On the other hand, it gives the program less independence and flexibility. Both accountability and independence are needed. Therefore, Cal Care will employ the Proposition 36 model of intermittent, mandatory legislative review.

- **Review by the Legislature every five years.** "Clean-up" bills as deemed necessary.

- **Revenues earmarked exclusively for implementing Cal Care.** Earmarked revenues limit government flexibility in meeting the broader needs of Californians. Health care is one of the most fundamental and persistent of human needs and its funding should not be interrupted. The government has found ways to borrow from earmarked funds but on the whole has abided by the spirit of the laws and the public intent in ballot initiatives.

- **Authority to set tax rates and regulations.** The State Health Fund is authorized by the State Health Authority to establish accounts, payment mechanisms, tax structure, and regulations it deems necessary and appropriate.

- **Authority to establish electronic expenditure and payment methods and guidelines.**

- **Establish a Reserve Fund.** The key factor in determining the percentage of budget that will be earmarked for the reserve account is the expected rate of growth of funding in relation to the expected growth of costs. We expect to slow the growth of expenditures. However, we think it prudent in the first five years to fund the Reserve Fund based on growth rates in the

five years preceding implementation. When Cal Care has demonstrated consistent slow growth rates and accurate system cost predictions, we will base reserve-level funding on future funding and expenditure expectations. We expect this formula initially will fund the Reserve Fund between 5% and 10% of budget.

- **In consultation with the State Health Agency, recommend "clean up" bills, which may be introduced at any time.**

PRINCIPLES OF A TAX-BASED HEALTH CARE SYSTEM

- **Restructure of health system financing.** Cal Care is a publicly funded, private health care system. Taxes replace insurance premiums, deductibles, co-pays and other out of pocket expenses. All federal, state and county monies currently spent on health care are folded into the Cal Care Health Fund. These revenue streams include Medi-Cal, Healthy Families, Medicare, Champus, Indian Health Service, Veteran's Administration, Federal Employees Health Benefits, Ryan White CARE Act, Family PACT, state safety net fund (e.g., Realignment), and the medical component of Workman's Compensation. Private funds set aside for health coverage, such as retirement health care funds, are also folded in.

- **Stability of revenues.** Health system revenues must be relatively stable with regard to economic growth and downturns. Volatile sources generate recurrent funding crises and surpluses and make planning difficult. Stable sources allow the predictability that is necessary for appropriate decisions about reimbursement levels and benefits packages. Insofar as California's progressive income tax is heavily dependent on the realization of capital gains and stock options, its volatility would be too great to fund a health care system.

- **Broad-based incidence.** Broad-based taxes not only reduce volatility but also ensure that those receiving the benefits share the costs. A broad-based tax also minimizes the burden on any particular class of taxpayers. Public acceptance of a health tax is likely to be greater if it is understood to be financing a universal benefit, like Social Security or Medicare.

- **Equity.** Equity includes concepts of ability-to-pay, progressivity and horizontal equity, such that similarly situated taxpayers pay similar burdens. Equity and progressivity include the distribution of benefits as well as the tax burden. For example, the social security payroll tax is regressive, particularly as it is limited at the top end, but the distribution of benefits suggest that the system as a whole is progressive. Broad-based taxes that may be proportional or even somewhat regressive may, by providing universal health care benefits, have an ultimately progressive impact. At the same time, ability to pay must be a major consideration insofar as the poor may endure a significant out-of-pocket loss from a regressive system.

- **Efficiency.** Ease of administration and certainty of collection are essential. A tax that builds upon current levies and already has an enforcement/collection mechanism is far more certain than one that can be avoided, is new or has enforcement complexities. Insofar as this will be a new tax, it is likely to be less burdensome as part of a current tax collection processes.

- **Subsidies and Replaced Coverages.** The state of California becomes the sole payer and purchaser of health care. It offers a universal insurance plan that replaces all other coverages,

with the exception of policies for benefits not covered by Cal Care and short-term policies for tourists and those awaiting eligibility. The progressive health tax subsidizes health care for very low-income Californians. For a limited period of time the state subsidizes a portion of revenue loss that may occur as a result of state pharmaceutical purchasing policies.

- **Balanced Health Care Budgets.** Econometric modeling demonstrates that the Cal Care single payer system can provide universal coverage for $3.7 billion less than is now spent on health care. Costs and inflation are controlled by linking growth in spending to growth in California GDP and population and in other ways discussed under "Cost Containment."

CAL CARE TAXES

Cal Care is financed by federal, state and county monies currently spent on health care, a payroll tax, a surcharge on non-payroll income, and modest increases in tobacco, sales and alcohol taxes. It is hoped that California foundations will continue their generous support of health care programs.

FEDERAL, STATE AND COUNTY MONIES

All federal, state and county monies currently spent on health care will be folded into the Cal Care State Health Fund.

PAYROLL TAX

There will be a payroll tax levied on all California employers and employees. The rate for employers is 6.1% and for employees 3.6%. The tax is collected as a payroll deduction.

For a majority of Californians the payroll tax will be less than the insurance premiums they now pay. For employers who currently pay the insurance premium for employees, the payroll tax will be less than the insurance premiums. We expect the difference to go to employees in the form of increased wages.

For employers there are benefits to collection of a tax on all firms. It helps to level the playing field in hiring, stabilize workforces, improve worker satisfaction and decrease sick time. For the 66% of California employers who currently provide health benefits there are additional advantages. The need to find affordable health insurance and negotiate benefit contracts is

eliminated. The payroll tax is less than they now pay for insurance premiums. For employers who currently do not provide health benefits the payroll tax is a new operating expense. However, it is well understood that most if not all of the employer's share of the payroll tax is passed onto employees in the form of deferred or lowered wage increases, fewer job offerings and unfilled job vacancies.

Cal Care evaluated the effect of exempting the first $7,000 of income from the payroll tax. The charts on the following pages show the payroll taxes that would be paid by employees (with and without the $7,000 exemption) and the family savings under Cal Care.

Cal Care Payroll Tax: Employees

Employee Payroll Tax With $7,000 Exemption, 4.2 %

Gross salary	Taxable Salary	4.2% tax	Tax per year	Tax per month	Tax per hour
$10,000	$3,000	0.042	$126	$10.50	$0.06
15,000	8,000	0.042	336	28.00	0.16
25,000	18,000	0.042	756	63.00	0.36
35,000	28,000	0.042	1,176	98.00	0.57
45,000	38,000	0.042	1,596	133.00	0.77
55,000	48,000	0.042	2,016	168.00	0.97
65,000	58,000	0.042	2,436	203.00	1.17
75,000	68,000	0.042	2,856	238.00	1.37
85,000	78,000	0.042	3,276	273.00	1.58
95,000	88,000	0.042	3,696	308.00	1.78
105,000	98,000	0.042	4,116	343.00	1.98
115,000	108,000	0.042	4,536	378.00	2.18
125,000	118,000	0.042	4,956	413.00	2.38

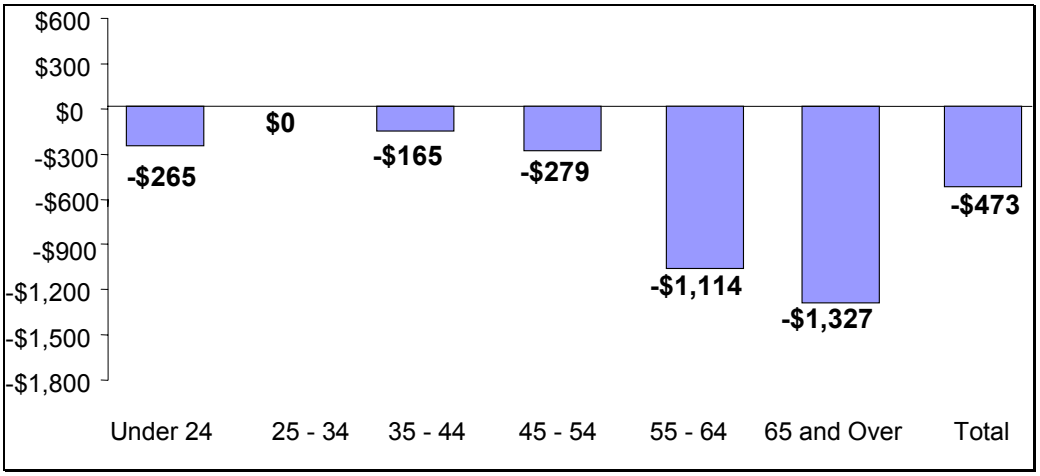
Source: Peter Conn and George Delury for Health Care for All-California.

Employee Payroll Tax Without $7,000 Exemption, 3.6 %

Gross salary	3.6% tax	Tax per year	Tax per month	Tax per hour
$10,000	0.036	$360	$30	$0.17
15,000	0.036	540	45	0.26
25,000	0.036	900	75	0.43
35,000	0.036	1,260	105	0.61
45,000	0.036	1,620	135	0.78
55,000	0.036	1,980	165	0.95
65,000	0.036	2,340	195	1.13
75,000	0.036	2,700	225	1.30
85,000	0.036	3,060	255	1.47
95,000	0.036	3,420	285	1.65
105,000	0.036	3,780	315	1.82
115,000	0.036	4,140	345	1.99
125,000	0.036	4,500	375	2.17

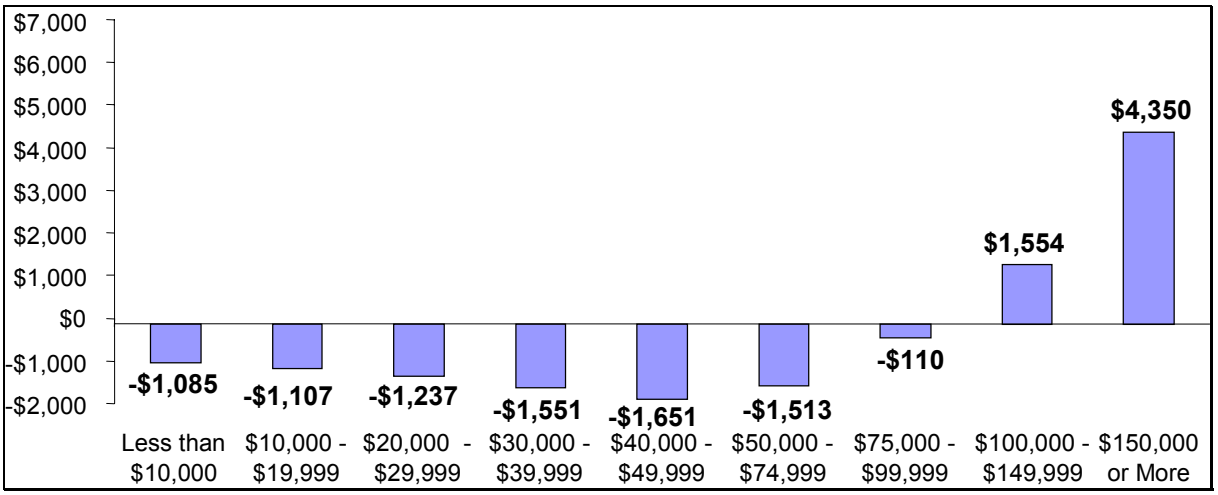
Source: Peter Conn and George Delury for Health Care for All-California.

Change in Average Family Health Spending by Age of Family Head Under the Cal Care Single Payer Proposal in 2002: After Wage Effects [a/]



[a/] Assumes Full Implementation
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Change in Average Spending Per Family Under the Cal Care Single Payer Proposal in 2002: After Wage Effects [a/]



[a/] Assumes Full Implementation in 2002
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Revenues collected through payroll are more stable than general tax revenues because gross payroll varies less than taxable income. Gross payroll will rise and decline with the level of unemployment and wages but always within a few percentage points. California's progressive income tax is more volatile with swings as high as 15% from year to year because most income tax revenues come from wealthy taxpayers (10% pay 70% of the income tax) and depend to a great extent on capital gains, income and stock options.

The payroll tax is far more broad-based than the income tax. It captures a contribution from all working Californians, including independent contractors and self-employed individuals, although a separate collection mechanism must be designed for these persons. It captures all payroll costs, except underground economy costs, and is easily enforceable as a piggyback on current payroll taxes. Many working poor and low-income families are not currently part of the income tax system, which collects taxes on only about 60% of households. This is because the tax is structured with substantial bottom-end exemptions. A family of four, earning less than approximately $40,000, will pay no income tax. That may be admirable as a matter of tax policy, but it means that many of the beneficiaries of universal health care would pay nothing for their care. Insofar as the benefits of the system will go to everyone, it is appropriate for everyone to pay their fair share.

SURCHARGE ON INCOME NOT SUBJECT TO PAYROLL TAX

There will be a 2.8% surcharge on the following sources of non-payroll income: taxable interest, taxable dividends, taxable pensions and annuities, taxable business income, capital gains, rents and royalties, partnerships and "S" corporations, estates and trusts, and other sources. These are sources of income that should help fund the health care system but are not reached through a payroll tax.

TOBACCO TAX

There will be a tax of $1.00 per pack and per tobacco product.

SALES TAX

There will be a ¼-cent sales tax, which raises $1 billion. This amounts to $30-$100 per family, depending on family size and income. For some Californians the sales tax may be the only contribution they make.

ALCOHOL TAX

There will be a tax on alcohol sufficient to raise $2 billion. The monies raised by the tax are earmarked for alcohol-related health programs. The estimated tax rates are as.

- 15 cents per can of beer (12 oz.)
- 32 cents per bottle of wine (750 mls.)
- 48 cents per bottle of champagne, (750 mls.)
- $5.00 (approximate) per bottle of distilled spirits (100 proof or less)

Source: California State Board of Equalization, March 2002.

The elevated rate for distilled spirits (hard liquor) is because of its high alcohol content compared to wine, beer and champagne. To keep the California wine industry competitive, we will consider a tax credit on exported wine equal to the margin of increase in alcohol taxes imposed by Cal Care. The net effect, therefore, would be no change in the tax on exported wine products.

In California in 1995, the cost of alcohol abuse, including lost productivity, vehicle crashes, fires, criminal justice, and treatment programs was over $16 billion dollars, according to the National Institute of Drug Abuse (NIDA). In that year approximately $660 government million dollars were spent to defray these costs. Although most alcohol consumption is responsible, all

Californians will benefit from alcohol education and treatment programs that lead to safer highways, less congested emergency rooms, diminished productivity losses, declining medical, court and jail costs and fewer devastating personal losses.

CONTRIBUTIONS FROM FOUNDATIONS

Cal Care will work with California foundations to seek continuation of the creative participation and generous funding they contribute to the health care system.

COST CONTAINMENT

THE CRISIS IN HEALTH CARE SPENDING

High rates of growth in health care spending are a mounting threat to health system finance. Current cost control methods, including the introduction of managed care, have failed to stem the tide. The U.S. now spends $4,637 per person annually for health care (health expenditures divided by population).[1] This is twice as much as the average spent in other industrialized, developed nations, all of which have better health outcomes than the United States and all of which provide universal health coverage. On March 12, 2002, the U.S. Health and Human Services Centers for Medicare and Medicaid announced that these costs are expected to double by 2011, so that we will be spending $9216 per person. France, which is ranked number one in the world for health outcomes by the World Health Organization, spends around $2,100 per person.

Rising costs reverberate throughout the health care system. The Washington Post reported in September 2001, that federal insurance premiums were 50% higher in 2001 than in 1998. The Kaiser Family Foundation with the Health Research and Education Trust reported that premiums for employers were up 11% in 2001, more than double the 4.3% general inflation rate. Elderly and disabled members of Medicare HMOs used nearly 50% more of their own money for medical care in 2001 than they did three years earlier, according to Mathematica Policy Research, a nonpartisan research center in Washington DC. Health spending could reach $2.8 trillion by 2011 or 17% of the nation's gross domestic product (GDP), up from 13.2 % in 2000, according to the U.S. Centers for Medicare and Medicaid. If U.S. health care spending had been held to GDP growth over the past two decades, it would be 25% below the current level.

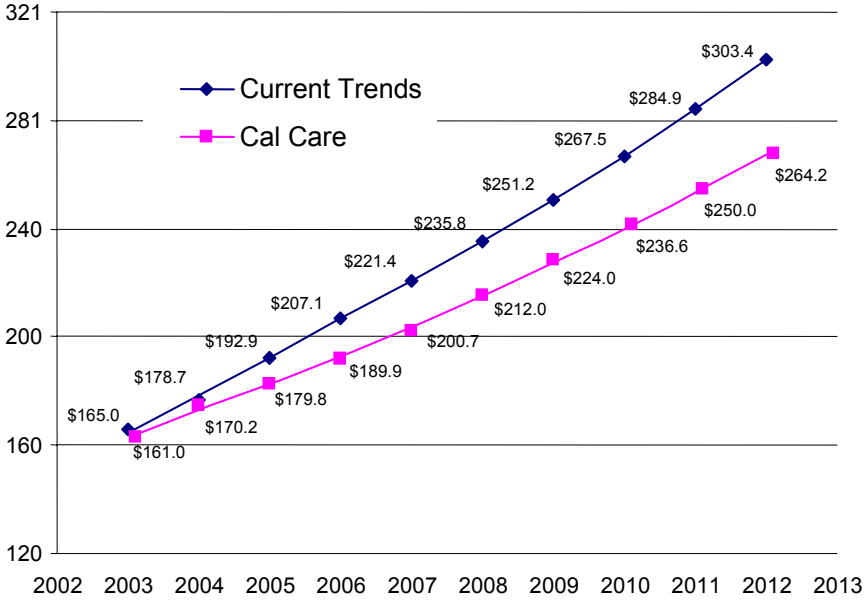
COST CONTAINMENT TOOLS

Cal Care uses classic single payer cost containment tools to control the growth of health care spending. Three were discussed under "Health Care Planning and "Governance" (streamlined administration, system wide health care planning and emphasis on primary care). Here we focus on seven additional cost containment tools: health spending benchmarks, global health care budgets, "single buyer" purchasing policies, physician utilization constraints, centralized electronic claims and payment systems, public-private partnerships, and a selected co- pay.

HEALTH SPENDING BENCHMARK

In an integrated health care system with coordinated statewide planning, the growth of health care spending can be regulated. A benchmark for spending growth is established. It is implemented using a variety of cost containment tools. Spending is monitored and adjustments are made as needed. Under Cal Care, the benchmark for spending growth is the rate of growth of California GDP. The following graph shows the effect of the linkage of growth in health spending to growth in California GDP.

Projected Growth in Health Spending Under Current Trends and Cal Care 2003-2012 (In billions)



Source: Lewin Group estimates.

GLOBAL BUDGETS

A global health care budget is a prospectively set expenditure limit on the resources devoted to health care. The concept includes all resources spent to deliver care, govern, regulate and monitor the system, gather and analyze information, and plan for resource distribution. The global budget is disaggregated by sector.

A. Global Budget for Health Services. A budget is established for all health care services including utilization by newly insured and currently underinsured Californians. New utilization is estimated by assuming services are used at the same levels used by others of similar demographics, adjusted for reductions in acute and emergency care that result from extension of preventive care to the entire population. Budgets are risk adjusted to better reflect the costs of providing services. Weighted formulae are used to ensure adequate funding to meet service shortages and improve outcome deficiencies.

B. Global Budget for Purchasing. This is discussed under "Purchasing Policies."

C. Global Budget for Administration. This is discussed under "Cal Care Governance."

D. Global Budget for Capital Allocation. Coordinated planning of capital expenditures statewide can yield savings. The magnitude of these savings was not calculated by The Lewin Group. Nevertheless, there is little doubt that eliminating investment in redundant, underutilized capital assets and the costs of maintaining them will save money. Cal Care capital allocation is based on the following guidelines:

1. Capital growth rate is limited to growth of California GDP and population.
2. Regional health planners identify regional capital needs and transmit this information to the Health Agency.
3. State Health Agency prioritizes among competing statewide needs. Early priority given to correction of shortages and outcome deficiencies and seismic retrofits.
4. State Health Agency develops global and regional capital budgets.

5. Health Fund administers and disburses capital budget monies.
6. Private investors may commit private capital to health system projects. All capital expenditures over $250 million dollars require State Health Agency approval. State Agency may delegate this authority to regional health planners. When seismic retrofits are complete the State Health Agency will consider raising the $250 million limit.
7. Projects funded with state monies are property of the State of California. Projects funded by state and private monies are jointly owned. Privately funded projects are privately owned.
8. Those receiving state capital funding must apprise the Health Fund and regional authorities of progress on capital projects including conformance with budget limits. Regional planners and the Health Fund have authority to intervene to assure budget conformity, including discontinuance of a project. Regional planners may delegate authority to County Health Officers if deemed appropriate.

A challenging problem is the separation of capital and operating budgets for large integrated systems and placement of planning authority in an outside entity, in this case, the state. In order for integrated systems to manage care and costs internally, they must manage growth over time across their own systems. Some will argue they are managing care inappropriately by shrinking benefits and access, and increasing charges. On the other hand, if an integrated system is meeting quality and performance standards and not experiencing patient and provider dissatisfaction, should it be allowed to manage its own capital growth?

E. Global Budget for Facilities and Integrated Systems. The State Agency establishes an annual global budget for hospitals, clinics and integrated health systems. Through the process of negotiating risk-adjusted facility and provider budgets, County Health Agencies and regional planners determine how global budget monies are allocated locally. In developing budgets they take into consideration past expenditures weighted for projected changes in services and wages, equipment and pharmaceutical needs, regional health outcome deficiencies, the cost of treating complex illnesses, reductions in administrative overhead, previously uncompensated costs of care, regional differences in medical practice, flexible fee adjustments, and other parameters. To eliminate incentives to decrease or increase care, hospitals and facilities are prohibited from using operating budgets for expansion, marketing or major capital purchases or leases. Global

operating budgets provide stable and predictable income and relieve funding uncertainties experienced in the current system.

F. Global Budget for Providers. The State Health Agency establishes a global budget for providers. Providers are reimbursed on a fee-for-service basis or on a salaried basis as employees of facilities, group practices and integrated delivery systems. Salaries are included in facility operating budgets. Fees for service are negotiated between regional and County Agency planners and provider representatives. Initial reimbursements are set in accordance with union contracts, where they exist. Cal Care will explore the reimbursement model used in Germany, where global provider budgets are set by the state but distribution of fees among physicians is the task of physician self-administration structures. To contain costs, provider reimbursement levels will decline as global budget ceilings are approached.

G. Global Budget for Research and Innovation. An office within the State Health Agency is established to standardize and coordinate information gathering and analysis, to provide financial support and oversight for research and development, to assure equitable deployment of advanced health technology, and to link research, innovation and health system goals.

H. Global Budget for Displaced Workers. The Transition Commission and the State Health Agency will determine the level of funding needed to retrain workers displaced from jobs in the transition to single payer system. Budgets will include retraining funds for at least two years. Cal Care will work with the Legislature and the Governor to estimate the costs of additional support that may be needed such as unemployment compensation. Health worker training programs will be encouraged to give priority to the applications of displaced workers. When appropriate, public-private partnership contracts will require that displaced workers application be given priority consideration.

"SINGLE BUYER" PURCHASING POLICIES

Under Cal Care the California government, represented by the State Health Agency, becomes the "single buyer" for pharmaceuticals, medical supplies and other health care products and uses its purchasing power to win large discounts. According to the Lewin Report, Cal Care purchasing policies could have saved California $3.64 billion in prescription drug costs in 2001. These savings would allow Cal Care to provide a prescription drug benefit without a co-pay to every Californian.

San Francisco Chronicle

[redacted]

Wednesday, October 17, 2001

….Shortages of the Bayer drug Cipro -- whether created by a genuine anthrax emergency or by panic buying -- may convince Bush administration health officials that they want the generic drug, ciprofloxacin, which Bayer sells as Cipro, more than Bush administration trade officials want Bayer's patent protected.

U.S. budget officials could also decide to buy cheaper generic drugs.

Alternatively, U.S. consumers may become outraged to learn that while Cipro has cost nearly $350 per month in the United States, a generic drug from reputable suppliers costs only $10 per month in India….

Donald G. McNeil Jr., New York Times

PHARMACEUTICALS

U.S. spending per person on drugs is the highest in the world and is doubling every five years. Retail drug spending has increased by 116.4% to $165 billion, since 1994.[42] More than 70 million Americans, including 10 million Californians, have no insurance for prescription drugs

Cal Care's pharmaceutical purchasing policies combine regulatory and market techniques to lower drug prices, make needed medications affordable, safeguard legitimate research, and support profitability of the pharmaceutical industry at a fair level.

Pharmaceutical purchasing policy hallmarks:

- Establish state authority over pharmaceutical purchasing through legislation, including "clean up" bill authority. Create a State Purchasing Agency as part of the State Health Fund.
- Announce prices at which California will purchase pharmaceuticals, based on Federal Supply Schedule (FSS) prices and other discounted federal price options.
- Seek federal, state and county conforming legislation and agreements.
- Maintain manufacturer profit at fair levels. Universal health coverage expands market for pharmaceuticals by 10 million persons. This market expansion offsets losses from lowered prices. Consider subsidies during first five years if market expansion insufficient to maintain pharmaceutical profit at around the average profit levels across other major US industries, (16%).
- Establish state oversight of research. Coordinate state and federal research funding.
- Identify health-based research needs.
- Identify true research costs. Work with pharmaceutical companies and other research entities to assure funding of true research costs. Eliminate support for "copy cat" and profit-driven research unlikely to meet identified health needs.
- Establish closed formularies.
- Maintain existing wholesale distribution networks at a fair rate of return.
- Maintain existing retail distribution networks at a fair rate of return.
- Negotiate purchasing arrangements early to allow for production adjustments. The marginal cost of manufacturing increased volume for the expanded market is small.

State Authority over Pharmaceutical Purchasing. The State Purchasing Agency will implement pharmaceutical purchasing policies and evaluate their effectiveness. In the first two years of operation, the State Purchasing Agency may pay less but will pay no more than Federal Supply Schedule (FSS) prices or other federally established prices. The Federal Supply Schedule

is a list of discounted prices offered by the federal government to large buyers such as the military, state and city agencies, and some foreign countries. If California paid FSS prices in 2001, there would have been a 36% saving over and above the Medicaid discount.[42]

In subsequent years, California will purchase drugs at prices paid in Canada and Europe. If Californian paid average Canadian prices for brand name drugs, the savings this year would be 36.7% savings.[42] If we paid Italian prices, the savings would be 48%, and for French prices, 42.6%. There is no perceptible industry exit from these markets.

We will not import drugs from abroad to lower costs. We expect manufacturers would dry up foreign sources by exporting lower volumes, holding down volumes produced abroad and threatening higher foreign prices for those who export. We will not rely on market mechanisms in place today to lower drug costs, such as pharmacy benefit managers, generic substitution, and managed prescription writing. They have not gotten the job done for many reasons. We will not institute co-pays on prescription drugs. They are expensive to administer, are a disincentive to appropriate utilization and they disproportionately affect low income Californians. They force people to choose between medications and other essentials such as food, clothing and school supplies.

Support Fair Manufacturer Profits. Cal Care includes a prescription drug benefit for all Californians. This expands the market by 10 million people. Higher sales volume offset losses from lower drug prices. It is important to encourage cooperation between the pharmaceutical industry and the single payer system. Therefore, Cal Care will consider subsidizing industry profits for up to five years if revenue losses due to state purchasing policies are not offset by expanded market volume. Subsidies would maintain pharmaceutical profitability at a rate of return on equity equal to average rates experienced by a broad sampling of other U.S. industries.

Drug industry profit levels are extraordinarily high. Data indicate drug industry return on equity is 35.6% compared to a 16.1% median return over 41 other US industries.[42] Some drug makers may hide an even higher rate of return by reporting consolidated corporate-wide results rather than reporting returns from their drug manufacturing operation alone. Such elevated profits will not be subsidized.

Protect Research. Pharmaceutical companies claim that research will be compromised if prices are cut. Is this true? Recent studies indicate that drug companies spend less on research than we have been led to believe. Six major drug makers spend as little as 11% of total expenditures on research. Between 1990 and 2000, research employment grew 10%, while employment for administration and marketing grew 57%.[42] [43] Perhaps a more honest statement is that profits will be compromised if prices are cut.

Cal Care will endeavor to determine the true costs of needed research. The level of profit necessary to support true costs and encourage innovative research, produce breakthrough drugs that meet statewide health needs, educate providers, and maintain the number and diversity of producers necessary to support innovative research will be taken into consideration in determining any subsidies. Support for development of "copy cat" drugs will be in proportion to the extra clinical benefits they achieve, such as fewer side effects or greater efficacy. The state will work with drug companies, public, private and federal research entities, and universities to identify mutually beneficial research priorities linked to health planning goals.

Establish Closed Formularies. Closed formularies allow the safest and most efficacious drugs to be identified and made available to the public in a coordinated fashion. They facilitate coordinated withdrawal of ineffective, marginally effective or unsafe drugs. Health care professionals will determine which drugs will be in the formulary. For the first two years of

system implementation, the Kaiser Permanente formulary will be the benchmark. Closed formularies are a disincentive to expensive and wasteful marketing efforts. such as direct advertising appeals to consumers. Physicians may prescribe non-formulary medications if they deem it essential to the health of their patient. Ordering outside formulary will be closely monitored.

Maintain Wholesale and Retail Networks. The state will be the purchaser of drugs but not the distributor. California has efficient and cost effective distribution and retail networks. In another example of public-private partnerships, the State Health Fund will contract for distribution services and negotiate a fair rate of return.

MECHANICS OF PHARMACEUTICAL PURCHASING

1. State Health Agency announces the FSS prices it will pay for pharmaceuticals.
2. State Purchasing Agency (an office of the Health Fund) negotiates contracts with wholesales for distribution services.
3. State Purchasing Agency negotiates retail reimbursement rates.
4. State Purchasing Agency purchases pharmaceuticals.
5. Manufacturers distribute pharmaceuticals to wholesalers.
6. Wholesalers distribute pharmaceuticals to retailers as per retail orders.
7. Retailers fill prescriptions and bill state for services.
8. Patients fill prescriptions for no charge at point of service.

DURABLE MEDICAL EQUIPMENT (DME)

We looked at two purchasing models to lower prices for DME, laboratory supplies and non-perishable food products. One is based on Medicare DME demonstration purchasing projects, the other on purchasing at Federal Supply Schedule and other federal discount prices.

Medicare Demonstration Projects for Lowering the Price of DME. Three-year demonstration projects to lower DME prices are underway in Polk City, Florida and San Antonio, Texas. Florida is in its final demonstration year; San Antonio is in its second year. The projects use a carefully constructed system of competitive bids issued by Medicare, the single buyer. The projects were authorized by the Balanced Budget Act of 1997 and are overseen by HCFA, now named the Centers for Medicare and Medicaid Services (CMS). The projects are attractive because they combine fiscal soundness with high standards of quality and service.

At the nine-month evaluation point, Medicare costs in Polk County for DME were reduced by 17%, a savings of more than $1 million to Medicare and $250,000 to beneficiaries for the tested items (oxygen and associated support equipment, hospital beds and accessories, enteral nutrition products, urologic products, and surgical dressings). No substantial barriers to access

were demonstrated, despite a smaller number of providers (the selected bidders). Results demonstrated maintenance of quality of product and service. At two years, the savings averaged 20%. Quality and access were maintained.

The project also looks at the effect of competitive bidding and a single buyer on the competitiveness of markets. At two years, they concluded that once prices are established, suppliers compete on the basis of quality and service to increase market share. They noted that the most common winning bidding strategy was to vary the percent of discount across most procedures in a product category. Few lowered all items by the same percentage.

At nine months, project managers were confident that Medicare (the single buyer) could implement a competitive bidding system. They recommended that education and publicity be done in the community well in advance of the bid and that bids should focus on price, supply capacity, and product and service quality. They noted that claims were being smoothly processed. They felt that an on-site ombudsman greatly facilitated implementation.

Demonstration projects descriptions, documentation and results are included in Appendix C.

Our second approach to lowering costs for DME involves purchasing at Federal Supply Schedule and other federal price benchmarks, as discussed with pharmaceuticals. We discuss it here briefly.

- Legislate authority over DME purchases to a State Purchasing Agency (SPA).
- SPA negotiates contracts with manufacturers at FS, 102-585 and other federal price benchmarks.
- SPA utilizes diverse contract models as federal purchasers do.

If California used either of these cost containment policies -- competitive bids or discount purchasing -- the savings could be substantial. The unanswered question is whether the administrative costs of competitive bids and ongoing interaction with multiple suppliers would

offset potential savings. Because of the uncertainties of the competitive bid approach, at this time we recommend DME purchasing based on federal price discounts.

FAILED DISCOUNT PURCHASING EFFORTS

According to the National Acquisition Center, the agency that negotiates purchasing contracts for the federal government, California has twice passed legislation asking for access to FSS and 102-585 price schedules. California has never implemented the legislation. Needed federal conforming legislation was never sought although there is precedent in federal policy to extend FSS price advantages beyond the military. Another issue in the failure to implement the FSS access legislation was the failure to solicit cooperation from cities and counties. This cooperation is essential to the success of such a program. Access to FSS and other federal prices has been authorized for other countries, for nearly all federal agencies and city government agencies in Washington, D.C. These are just a few on a long list of Government Service Agency authorized FSS customers. There is no reason California cannot be an authorized FSS customer.

PHYSICIAN UTILIZATION CONSTRAINTS

All health care systems impose constraints on provider spending. Cal Care seeks a policy that respects the sanctity of the physician-patient relationship and builds cost-containment consciousness among providers. Cal Care will:

- Familiarize providers with health system planning and finance goals and the impact of their practice behaviors through mandatory classes in all health professional and ancillary health professional training programs and through mandatory continuing medical education.
- Improve physician awareness of how their practice conforms to or varies from community practice patterns through peer review.
- Involve providers in Cal Care decision-making bodies.
- Develop and implement standards of care and best clinical practice standards through clinical advisory groups and coordinated care trials.

- Link research to medical practice needs and disseminate information to providers through innovative data management techniques.
- Consider having physician representatives determine physician fee distribution.
- Implement flexible provider fees that decrease by region and/or provider specialty when expenditures approach global budget ceilings.
- Allow providers to monitor spending through accessible information systems.
- Detect fraud through anti-fraud awareness training and appropriate high technology.
- Enhance communication among medical practices using advanced information systems.
- Finance incentives to increase enrollment in primary care, pediatric and occupational health training programs.
- Establish a Malpractice Assurance Fund similar to the Canadian model, to provide malpractice insurance, legal services and malpractice pay-outs. This spreads risk across the system and lowers individual premiums. As seen in Canada, we expect fewer lawsuits because people do not have to sue for the costs of their medical care under a universal coverage.

CENTRALIZED ELECTRONIC CLAIMS AND PAYMENT SYSTEM

All claims will be filed and paid electronically. The State Health Fund will develop a public-private partnership for claims processing and payment systems. Through a competitive bid the Fund will subcontract with private insurance companies or other appropriate institutions for these services. Shifting the health insurance industry to work needed by the single payer system will help maintain their viability in California and provide employment for their workforce.

PUBLIC-PRIVATE PARTNERSHIPS FOR HEALTH

Public-private partnerships are business ventures that advance health system goals in a cost-effective manner. They take advantage of existing resources, skills and experience; they create business opportunities; and they mitigate job loss in the health insurance industry. They are used successfully in single payer systems around the world.

Priorities of the partnerships are to achieve health system goals, to induce mutually beneficial collaboration between business and the single payer system, to create employment, especially for displaced workers, and to assure good working conditions. Fair rates of return for business partners and prevailing wage and benefit packages for employees are always a part of public private partnership contracts.

The importance of protecting employment for the health insurance workforce cannot be overstated. In a single payer system the insurance industry as we know it will no longer exist. Unless the single payer system is proactive, the new system will be disastrous for health insurance employees. This must not be allowed to happen. The vehicle to prevent this is to shift the health insurance workforce to new employment within the single payer system and to pay for needed retraining. There will be an abundance of new undertakings, most of which will be more interesting than insurance adjustment. This policy builds on the successful Australian Health Insurance Commission (HIC) model. (See "View from Abroad.") HIC has become the dominant health system administrative entity and a leader in the development of quality of care programs. It is our hope that the California health insurance industry will make a similar transformation.

Cal Care public private partnerships are initiated in two ways:

1. The State Health Agency, or its designee, issues a competitive bid and partner with a private business, educational institution or private foundation.
2. Private industry, educational institutions, private foundations, individuals, or other entities make a partnership proposal to the state.

Public-private partnerships will be useful in many arenas, such as:

- Linkage of research to health system goals.
- Design of cost-effective claims submission and payment systems.
- Manufacture and distribution of health system cards.
- Development of non-social security identifiers.

- Development of capital allocation and risk adjustment methodology.
- Demonstration projects of all kinds.
- Wholesale and retail distribution of pharmaceuticals and durable medical equipment.
- Development and deployment of advanced health information systems.
- Development of "best medical practice" guidelines.
- Development and implementation of physician education programs.
- Development of information systems for public and health professional education and interaction.
- Creation of the Malpractice Assurance System (state malpractice insurance).
- Development and evaluation of health professional staffing ratios.

CO-PAYS

Co-pays are, in effect, highly regressive taxes that can add up quickly and become a serious financial burden if one becomes ill or uses multiple medications. Co-pays are costly to administer, are disincentives to appropriate care and affect low-income people disproportionately. They contribute to the threat of bankruptcy. The U.S. is the only industrialized nation that allows families to enter bankruptcy as a result of serious illness.[44]

Some co-pays don't have these adverse effects and may serve a useful purpose. One example is a co-pay on specialty care sought or provided without a primary provider referral. Patients should not be expected to determine when and what kind of specialty care they need. This should be decided in consultation with one's doctor. A co-pay on unreferred specialty care encourages such doctor-patient collaboration. Patients can avoid the co-pay by consulting with their primary provider. Cal Care does not place limits on referrals by primary care physicians and will use a $25 co-pay on unreferred specialty care.

Cal Care evaluated the impact of three co-pay systems: No co-pays, co-pays on all services and a co-payment on specialty care received without a referral. The results are shown below.

Single Payer Costs and Revenue Required Under Three Alternative Co-Pay Models in 2002

(In millions)

	No Co-Payments a/	$25 Co-Pay for Un-Referred Specialty Care b/	$5.00 Co-Pay for All Services c/
Program Spending			
Benefits			
Acute Care	$135,124	$131,296	$123,838
Other Services	$16,957	$16,957	$16,957
Bulk Purchasing Savings	($4,032)	($4,032)	($4,032)
Adjustments to Provider Payments			
Cost Shift Adjustment	($4,411)	($4,411)	($4,411)
Provider Administration	($7,550)	($7,430)	($7,022)
Program Administration	$2,343	$2,393	$2,393
Total Spending	$138,481	$134,773	$127,723
Financing			
Current Program Funds	$65,694	$65,694	$65,694
Net New-Revenue Requirement	$72,787	$69,079	$62,029

a/ There would be no co-payments for any of the acute care services under this plan.
b/ There would be no co-pay for primary care and specialty referrals, with a $25 co-pay for un-referred specialty care.
c/ There would be a $5.00 co-pay for all services, plus a $25 co-pay for specialty care without a primary care referral.

SUMMARY

The Lewin Group Report confirms that Cal Care single payer policies will control costs and generate a cumulative savings of around $220 billion over the first decade of operation. Similar savings were demonstrated in the 1991 Government Accounting Office (GAO) study of the likely effects of adoption of a national single payer system. Translated into today's dollars, the GAO calculated that the U.S. can expect to save $56 billion in physician and hospital administration costs and $58 billion in insurance overhead, for a total savings of $114 billion.[45] The cost of insuring the currently uninsured would be $61 billion. With a single payer system the nation's net savings over one year would be $53 billion. Thus, credible federal and state studies have demonstrated the fiscal effectiveness of single payer.

RISK IN A SINGLE PAYER SYSTEM

Under Cal Care the state of California assumes the financial risk of insuring the entire population. Risk is affected by a number of factors:

- Universal coverage spreads risk over a large number of persons, decreasing risk to the system as a whole.
- The State Health Agency has full authority over the funds that finance the health care system. It sets and modifies payments and benefits as necessary. It formulates and modifies the tax structure to maximize the stability and volume of revenues. It establishes a reserve at the level it deems appropriate and draws on it when necessary. It is backed by the resources of the state, which are accessible through the political process.
- Single payer cost efficiencies permit robust funding of universal health care services. This improves the health of the population, decreasing financial risk.

Some risk is assumed by integrated systems operating under global budget ceilings. However, operating budgets are risk-adjusted to reflect the true costs of meeting the health care needs of the population. Unmet performance standards or problems in budget management are the mutual concern and responsibility of the State Health Agency and the integrated health system.

In some sense the greatest risk is experienced by the health insurance industry and its employees. To an unknown extent their risk will be offset by involvement in public-private partnerships, by their shift into new jobs in the single payer system and by ongoing activity in non-health insurance markets.

As the World Health Organization comparative study of health outcomes in 191 countries demonstrates, universally insured populations are healthier populations. Good health is the ultimate moderator of risk.

RISK ADJUSTMENT

In a single payer system risk adjustment refers to the coordinated determination of payment levels to reflect the actual cost of providing health care services. The ability to perform effective risk adjustment is a function of available data and the ability to analyze it. Data and analytic capacity at the level required for effective risk adjustment are not uniformly available in today's health care system. It will be essential to correct this deficiency. Starting in the transition period information infrastructure will be assessed and needed changes initiated. There will be a role for public-private partnerships in many aspects of risk adjustment. We present two methods of risk adjustment that will be useful in a single payer system.

HCFA: PRINCIPAL INPATIENT DIAGNOSIS-DIAGNOSIS COST GROUPS

The Balanced Budget Act of 1997 required Medicare to link capitation rates to beneficiary health status by January 1, 2000. HCFA contracted with Health Economics Research to devise a system to accomplish this. Based on existing data constraints, they proposed adjustments be made based on the number of plan members, their age and sex, principle inpatient diagnoses, and diagnostic cost groups (PIP-DCG).

A weakness of this approach is that payments linked to hospitalizations may serve as an incentive for unnecessary hospitalizations. Adjusting payments according to inpatient and outpatient diagnoses would diminish this incentive and better reflect real costs.

JOHNS HOPKINS AMBULATORY CARE GROUP

The Johns Hopkins system measures the illness burden of individual patients. It assigns individuals to up to 32 different Ambulatory Diagnosis Groups (ADG) by clustering diagnoses coded on hospital discharge abstracts and physician claims over a defined interval.[46] Diagnosis codes are grouped into clinically meaningful categories based on expected clinical outcomes and

resource use. Individuals are also assigned to Adjusted Clinical Groups (ACG) using combinations of ADGs and patient demographics that describe the multiplicity of illnesses that contribute to level of services that an individual would be expected to consume. A study of the application of this system in Manitoba, Canada concluded that the system holds much promise. The Johns Hopkins system has been validated in the U.S. and in Europe as well.

RISK ADJUSTMENT EFFORTS IN CALIFORNIA

Some of the larger integrated systems anticipated changes to be imposed by Medicare and the impact they would have on revenues. They implemented comprehensive outpatient data collection systems tailored to the populations they serve. Their models may be applicable statewide.

GOVERNANCE

STATE LEVEL

STATE HEALTH COMMISSION

A State Health Commission is established to oversee the health care system. The Commission sets standards and broad policy goals and assures that the intent of Cal Care is implemented. The Commission is headed by an elected State Health Commissioner who is charged with the overall responsibility for assuring that the goals of Cal Care are met. Other Commission members are:

- Two County Health Officers appointed by the Commissioner.
- Three Commissioners appointed by the Legislature.
- Three Commissioners appointed by the Governor.
- Two County Consumer Advocates selected by a vote of County Consumer Advocates.

STATE HEALTH AGENCY

Under Cal Care, a single agency administers the health care system. It is created by consolidation of existing state administrative entities. Costly administrative functions performed by private health insurance companies are eliminated under single payer. These include ongoing assessment of individual risk, development and marketing of insurance products, evaluation of claims, treatment authorization and denial, payment of large executive salaries and issuance of stock dividends. The Lewin Group estimates that streamlining administration and eliminating tasks associated with private insurance will save $14.1 billion.

During the transition the Cal Care Commission, the directors of California Health and Human Services Agency, the Department of Health Services, the Office of Statewide Health Policy and Development, and others they deem appropriate will determine how existing

administrative agencies will be consolidated to mold a single State Health Agency. The Director of the State Health Agency is appointed by the Commission. The State Health Agency administers Cal Care and has the following responsibilities, many of which are performed cooperatively with regional planners:

- Develop a global budget for health care.
- Develop sector global budgets for: facilities, providers, integrated delivery systems, capital expenditures, health services (including prevention and education), administration, purchasing, research, innovation and information management, and displaced worker re-training and placement.
- Perform system-wide health services planning.
- Establish an eligibility and enrollment system.
- Adopt and modify the benefit package.
- Implement and coordinate information systems and assure equitable application of advanced technology.
- Perform ongoing assessment of the need for further administrative consolidation.
- Adopt regulations.
- Oversee licensing and accreditation.

COUNTY LEVEL

COUNTY HEALTH AGENCIES AND COUNTY HEALTH OFFICERS

There will be a branch of the State Health Agency in every county. The County Health Agency will be headed by a County Health Officer, who is appointed by the State Commissioner in consultation with County Boards of Supervisors. Public hearings will be held in each county to solicit nominations and input on the choice of County Health Officer. The County Health Officer and heads of existing county health agencies will determine how local agencies will be consolidated to form the County Agency. The County Health Officer has the following responsibilities:

- Participate in setting state standards and goals.
- Plan for needed regional and county health services, including assessment and prioritization of public health needs.
- Negotiate contracts and fees with local fee-for-service providers, based on state budgets limits.
- Negotiate facility and integrated systems operating budgets, based on state budgets limits.
- Determine regional and local capital needs.
- Establish and oversee regional and local capital budgets.
- Consult with and provide feedback to the Commission and State Health Agency planners.
- Implement, monitor and enforce standards of care.
- Establish an Office of the Consumer Advocate.
- Work closely with the County Consumer Advocate.

COUNTY CONSUMER ADVOCATE

Each County will establish an office of the Consumer Advocate. This office is created to put consumers at the policy table as equals and to protect and promote consumer interests. The Consumer Advocate will have sufficient staff and funding to accomplish the goals of the office. The performance of the Consumer Advocate will be evaluated at public hearings every two years. All candidates for this position and the appointed Consumer Advocate must demonstrate that they have no affiliations, connections, employment or investment interests that may pose a potential or apparent conflict of interest with their duty to protect and promote the concerns of consumers. The County Consumer Advocate has the following responsibilities.

- Receive and resolve grievances submitted by patients.
- Develop and execute consumer satisfaction surveys.
- Develop strategies to address issues of non-compliance with health care standards.

- Meet at least annually with other County Consumer Advocates to review data, discuss problems, develop strategies to address issues of non-compliance with health standards, and prepare policy recommendations for the State Health Commission and State Health Agency.
- Participate in regional health planning.

APPOINTMENTS

The Governor's appointees to the State Health Commission, the County Health Officers and the elected State Commissioner will serve terms concurrent with the Governor's term of office. Legislative Commission appointments will be staggered with one appointed for four years and two appointed for two years. To enhance accountability, all Commissioners including the elected Commissioner, and all health system appointees may be impeached for malfeasance of office. Standards for and an impeachment process will be determined during the transition phase.

Consumer Advocates are appointed by local Boards of Supervisors from a slate of candidates developed through public hearings. The Consumer Advocate may be re-appointed if re-nominated.

If a Commissioner appointed by the Legislature is unable to perform the duties of office or is impeached, the Legislature, through the offices of the Senate Pro-Tempore and the Speaker of the Assembly, in consultation with other state Commissioners, County Consumer Advocates and County Health Officers, shall appoint a replacement who shall serve the remainder of the term. If a Commissioner appointed by the Governor is unable perform the duties or is impeached, the Governor, through a similar consultative process will appoint a replacement. If the Director of the State Health Agency is unable to perform the duties of the office or is impeached, the Commission shall appoint a replacement. If a County Health Officer is unable to perform the duties or is impeached, the Commissioner will appoint a replacement, with input from Boards of Supervisors and other county health care stakeholders. If a County Consumer Advocate cannot perform the duties or is impeached, a replacement will be appointed replacement to serve the

remainder of the term. Permanent and replacement Consumer Advocates are appointed through the identical process.

ELECTIONS

According to the California Director of Elections Division, there should be no additional costs for adding an elected Health Commissioner to the state ballot. The only conceivable cost could be incurred if a candidate's statement added a fraction of an ounce to the postal weight, an unlikely eventuality.

FUNDS MANAGEMENT

The responsibility to secure, consolidate and manage funds will reside in the State Health Fund as discussed under "Finance." There will no longer be a need for other administrative agencies to secure and oversee federal health care funds.

KEY ASSUMPTIONS

- All Californians should receive high quality, culturally and linguistically-sensitive care.
- A single payer system can provide high quality universal coverage for less than we now spend on health care.
- A single payer system will improve the health of Californians in measurable terms.
- A single payer system will improve patient, provider and health worker satisfaction in measurable terms.
- Cal Care policies will stabilize costs and control the growth of health care spending.
- California will become a Federal Supply Schedule client.
- Single payer savings are substantial and offset the cost of insuring uninsured Californians.
- Federal, state and county funds now committed to health care are folded into the Cal Care.
- Cal Care can be enacted by legislation or ballot initiative.
- If an ERISA exemption is needed, it can be obtained.
- No Californian will lose any benefits they now have.
- County Consumer Advocates are effective consumer representatives.
- A single payer system will stimulate a creative surge in advanced health related technology development.
- A single payer system will effectively harness technology to meet health care needs and assure that all Californians share equitably in the benefits.
- Close to 100% of Californians can be enrolled in Cal Care.
- Demand for services can be met.
- Administrative systems are responsive and accountable.
- The health insurance workforce can be shifted into non-insurance employment.
- Public-private partnerships for health offer mutually beneficial business ventures and employment opportunities.

IMPACT OF A SINGLE PAYER SYSTEM

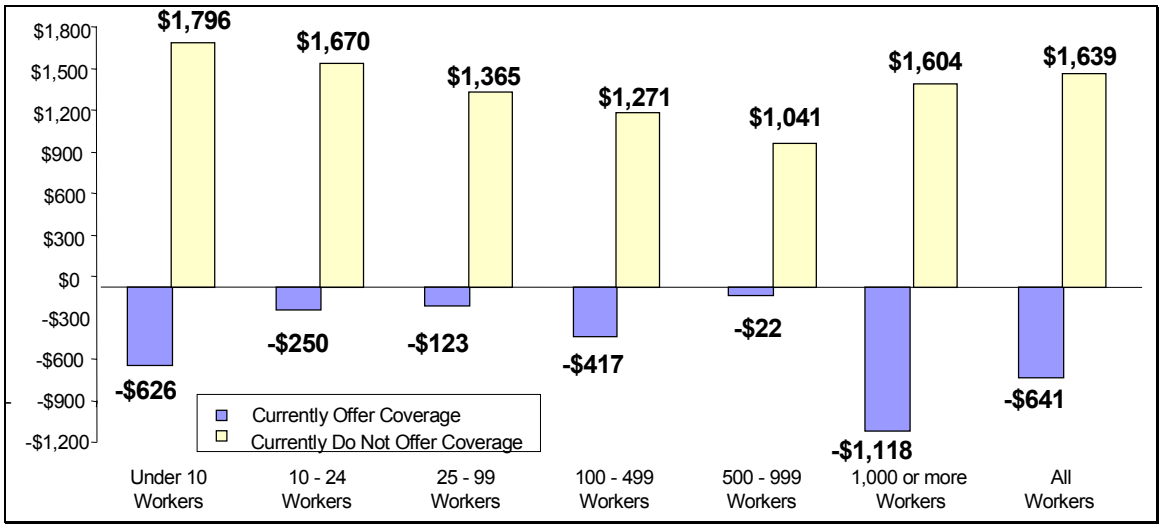
CONSUMERS

All Californian residents are covered with choice of provider. Coverage is not tied to employment or health status. Coverage can be lost only if California residency is lost. For most the health tax will be less than they now spend on insurance premiums, co-pays, deductibles, and other out of pocket expenses. For very low-income Californians the health tax is subsidized. No one will lose benefits they now have. Almost everyone will gain new benefits. Consumers participate in health system planning. Consumer interests are further represented by a funded Consumer Advocate in every county.

EMPLOYERS

Cal Care eliminates the contentious relationship between employers and insurance companies. Employers no longer negotiate health benefit contracts. Cal Care covers many services that employers now provide for retirees. Insurance premiums are replaced with a payroll tax on all employers. Uniform application of the tax helps to level the playing field in hiring, stabilize workforces, improve worker satisfaction and decrease sick time. As in today's health care system, employers pass on most of their health care costs to the employee. The graph on the following page shows the effect of the payroll tax before employers pass this cost on to their employees.

Change in Private Employer Health Spending Per Worker by Firm Size and Current Insuring Status Under the Cal Care Single Payer Proposal in 2002: Before Wage Effects [a/]



[a/] Assumes Full Implementation in 2002
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

PROVIDERS

The problematic relationship between providers and insurers over medical decisions and reimbursement is eliminated in a single payer system. Medical decision-making is returned to the hands of medical providers. Reimbursement is determined by negotiations between the providers and local health agencies and more closely reflects the true costs of caring for patients as money saved on administration, purchasing and other efficiencies is shifted into health care. Provider time and money spent on administration is greatly decreased. Equitable deployment of advanced health care technology statewide elevates provider capabilities.

WORKERS' COMPENSATION

Workers' Compensation is a vast statewide undertaking. An astonishing 900,000-1,000,000 occupational health injuries and illnesses were reported in California in 2001. Nearly 250,000 involved loss of work time. California currently spends $11-$12 billion annually meeting medical and disability needs. However, the real costs may be much higher because many injuries

and illnesses are not reported. For example, it is likely that many immigrant workers do not report injuries and illnesses for which they are covered under Workers' Compensation for fear of Immigration and Naturalization Service repercussions. Some workers won't report for fear of losing their job. In some cases employers discourage workers from reporting to avoid insurance premiums increases. Some employers have "incentive" programs that discourage reporting. Some even fail to carry mandatory Workers' Compensation insurance. Insurance companies spend time and money investigating claims in ways that have a dampening effect on reporting. Indeed, according to the insurers' Workers' Compensation Rating Bureau, nearly one-third of the budget of the 300-500 Workers' Compensation insurance carriers go to claims administration, loss adjustment, agents and brokers fees, and general overhead and not to health care services.

The problems facing Workers' Compensation reflect the problems facing the health care system as a whole. They include lack of attention to injury prevention, lack of quality oversight, low disability payments, lack of integrated access to information, fragmented and confusing lines of authority, inconsistent employer compliance, inadequate regulatory effort, lack of translation services, deficient training of health professionals in both workplace health and appropriate use of the Workers' Compensation system, insurance industry interference in medical decisions, insurance industry influence over social policy, poor provider reimbursement, rising insurance premiums, and poor linkage between programs.

In the current system, much time is spent attributing cause to worker injuries and illnesses and arguing over who will pay for care. In a universal coverage system, time and money will not be spent making such determinations. People will get the care they need regardless of what caused the problem.

Under Cal Care the medical and disability components of Workers' Compensation become part of the integrated health care system. This allows for a comprehensive and coordinated approach to the problems confronting the Workers' Compensation system today. During the transition phase, a Workers' Compensation Task Force will develop recommendations for reform of the finance, medical and disability components of Workers' Compensation, as well as a plan for their integration into Cal Care.

INSURERS

The market for private health insurance will shrink. The only policies sold will be for services not covered by Cal Care. These include short-term policies for those awaiting eligibility, policies for tourists, policies carried into California by visitors, policies that remain in effect while the transfer of authority is taking place. Public-private partnerships will, to an unknown extent, offset the loss of the health insurance market. Cal Care will retrain and otherwise assist in the shift of the health insurance workforce to non-insurance employment.

BUSINESS

Every business will pay a payroll tax. Health care products will be purchased at discounted prices. Revenue lost as a result of price discounts will be offset by expansion of the health care market. Expansion of coverage and public-private partnerships will create new business opportunities. We will see new building starts, new merchandise orders and new employment opportunities. We expect health-related markets to be robust once adjustments to the new system are made.

STATE AND COUNTIES

State and county health systems are re-organized and become part of an integrated health care system. The role of the state in health system finance, administration and planning is

expanded. Accountability of public officials is enhanced through public appointments and elections. Global budgeting allocates all health care resources system wide in a coordinated fashion based on identified system wide priorities and goals. Funding is stable and predictable for both the state and the counties.

THE "SAFETY NET"

Under Cal Care there is no persistent residual uninsured population. The "safety net" phenomenon, where millions are uninsured and only a small segment of providers care for them, disappears in a universal coverage system. There is no need to set aside funding for "safety net" providers and patients. Their needs, along with those of all other Californians, are provided for under Cal Care.

VIEW FROM ABROAD

In researching this proposal we investigated universal health care systems abroad. We looked for policies that might be useful in California. We found many promising possibilities and highlight a few of them here. The appendices have additional information.

FRANCE

- **Drug Pricing.** The cost of pharmaceuticals is low in France compared to the U.S. The government determines the price of drugs after discussions with producers. A reasonable profit for the company and distributors is allowed. The price set by the Government is the exclusive fixed retail price and is strictly enforced throughout the country. According to senior health system officials, the pharmaceutical industry in France is "very healthy."

- **Hospital Reimbursement - Democracy at Work.** The national government sets a global budget for hospitals. The regions then distribute funds to individual hospitals through regional councils ("conseils") whose members are elected by their peers.

- **Public-Private Partnerships.** At the regional level, all agencies of the health care system (Agencies de la Securite Sociale) are private organizations under government oversight. A private insurance company, Actuelles d'Assurance, and a public agency, Caisse Primaire d'Assurance, jointly manage claims processing and reimbursement and have partially integrated accounting systems.

AUSTRALIA

- **Public-Private Partnerships: Health Insurance Commission (HIC).** HIC is a private corporation that is an integral player in the health system. HIC is responsible for implementing a range of ambitious and innovative health programs and incentives. Originally, in 1975, HIC administered the distribution of health cards. In 1979, HIC installed what was then the largest online medical claims processing system. In 1983, HIC was chosen to administer the universal health insurance plan. In 1985, responsibility for medical fraud and over-servicing aspects of the system was transferred from the Department of Health to HIC. In 1989, administration of the Pharmaceutical Benefit Scheme was transferred from the Department of Community Services to HIC. In 1994, the Better Practice Program was launched and the Consultancy Division was added. In 1996, HIC started the Childhood Immunization Register. In 1998, they focused on a strategic plan to improve the health through enhanced use of accessible high quality information, research, coordinated care trials and disease management data to advise clinical groups and establish best practice standards. In 1999, they established the Information Management Division to coordinate use of information to improve health and the E-Business and Projects Division to develop e-business and make use of current and emerging technologies. HIC is now involved in the development of national and international standards for electronic data message formats and data structures. A recent example is their use of public key infrastructure electronic business and services. Public key infrastructure is a technology that provides a secure method of transferring information over the Internet. HIC uses this technology to allow medical practitioners to submit direct-bill claims electronically.

- In July 1999, they launched their "Charter of Care." which outlines customer service standards and performance benchmarks. The "Charter of Care" won the Australian Quality Council platinum award for excellence in all three categories of customer service. They instituted a system of 600 "Easy Claim" sit down booths, with free direct-dial phones to enable customers to lodge claims without filing forms.

CANADA

- **Public-Private Partnerships: Ontario Health Information Partnership.** These are independent research groups affiliated with provincial health planning authorities. They link health research to provincial health needs and play an important role in health planning.

- **Public-Private Partnerships: Health Intelligence Units.** The Ontario Ministry of Health contracts with five private research organizations to work with public health units and universities to help them access and use data appropriately. The Ontario Ministry of Health contracts with and funds community health centers to provide services to the homeless and others, with no proof of eligibility. The Manitoba Centre for Health Policy and Evaluation (MCHPE) is a university-based group active in health services research for the Province. It has one of the most complete, well-organized and useful health databases in North America.

- **Coverage for Non-Eligible Persons.** Short-term private policies are available for persons in the eligibility-waiting period.

- **Discretionary Services.** Certain services that are not in the general benefit package may be extended to targeted populations with special needs and may be partially or fully covered by the Province.

- **Electronic claims submission software**. Private vendors sell software to the Ministry of Health and to providers. Bills are electronically evaluated, and money is electronically deposited monthly into provider accounts. Submission deadlines (virtually no claims are accepted after 6 months) are a valuable budgeting tool because they allow planners to make good forecasts about health services spending.

GERMANY

Public-Private Partnerships: The German national health care system is mixed public-private finance and delivery model. Everyone is required to have an insurance policy and fees are deducted from whatever income one has. The partnerships are a fundamental part of the health care system. Providers and the Health Insurance Funds work together and neither can dictate policy unilaterally, a principle that extends to all players in the health care system. For example, the budget for pharmaceuticals is fixed jointly by the health insurance funds and the physician associations. The government sets reimbursement budgets, but the distribution of fees among physicians is the task of physician self-administration structures. The government establishes a long-term care benefit but everyone has the choice of using services rendered by the LTC fund contractors or receiving funds to support family caregivers.

TRANSITION AND IMPLEMENTATION

We have laid out a two-year, two-phase program for an orderly transition to a single payer system. In phase one (year one), a Transition Commission performs foundational tasks. In phase two, the permanent Health Commission initiates functional tasks. We identify key tasks in each phase and the sequence in which they would be accomplished. "A" tasks come first, followed by "B," " C," and "D" tasks. This format is a flexible tool to organize complex tasks.

PHASE ONE/YEAR ONE

TRANSITION COMMISSION: MEMBERSHIP

The Transition is initiated by appointment of a Transition Commissioner and a 26 member Transition Commission. Appointments are made jointly by the Governor and Legislative leadership, in consultation with representatives from each appointment category. The Transition Commission will include members with knowledge of the current system and of single payer. At least 19 commission members, including the Commissioner, shall have publicly advocated for single payer prior to enactment of the legislation or ballot initiative. Stakeholders will be represented on the Transition Commission as follows:

> 4 medical (fee for service, integrated systems, public health, public hospital), 2 nursing (managerial and bedside), 2 health workers union, 4 finance, 2 consumer advocate (consumer advocacy organization), 3 health system administration and governance, 1 legal, 2 health care industry, 1 hospital, 1 clinic, 1 health system regulator, 1 information technology, and 2 underserved populations.

The Transition Commission will form working Administrative and Planning and Finance Groups and Sub-Groups and may appoint additional persons to serve on these working groups.

TRANSITION COMMISSION, "A" TASKS: ADMINISTRATION AND PLANNING

- Estimate costs of transition and work with Legislature to procure appropriations.
- Recommend a process for statewide health planning.
- Recommend a plan for streamlining administration.
- Assess existing information and e-health technology. Recommend changes needed to meet single payer system goals and a plan to accomplish them.
- Initiate process for appointment of permanent Commissioners, County Health Officers and Consumer Advocates.

- Initiate process for election of Health Commissioner.

TRANSITION COMMISSION, "A" TASKS: FINANCE

- Constitute State Health Fund.
- Obtain needed waivers and conforming legislation to ensure that all funding sources are folded into the State Health Fund.
- Initiate estimates of system costs and magnitude of single payer savings.
- Initiate process for becoming Federal Supply Schedule state client.
- Initiate needed modeling for health tax structure.

TRANSITION COMMISSION, "B" TASKS: ADMINISTRATION AND PLANNING

- Survey existing health system capacity.
- Project increased service demand.
- Recommend a benefit package.
- Create Task Force to assure maintenance of existing benefits.
- Initiate demonstration enrollment projects. Devise enrollment systems.
- Assess regional capital investment needs, including seismic retrofits.
- Develop plan to form regional planning consortiums, including plan for stakeholder representation.
- Initiate needed improvements in health information and data reporting systems and other e-health systems.
- Design process for creating public-private partnerships for health.
- Identify needed public-private partnerships.
- Assess regulation and oversight systems. Develop reorganization plan.
- Develop impeachment process and standards.
- Assess magnitude of worker displacement. Recommend plan for workforce retraining and shift to employment in single payer system.
- Recommend plan and guidelines for impeachment.

- Plan for Office of Research and Innovation. Assess research needs. Plan for linkage of research to medical practice needs.

- Begin work with providers and community organizations to develop provider profiles and outreach teams to assist selection of primary providers and enrollment.

- Issue RFPs for the following demonstration projects: enrollment, on-site health facility child care, and public health education.

- Identify quality of care improvement priorities. Identify methods of assessing consumer, provider and health worker satisfaction benchmarks.

- Form Task Force to develop comprehensive reform of medical component of Workers' Compensation and plan for its integration into Cal Care.

- Design educational campaign, including "Frequently Asked Questions" and topical brochures to inform Californians about how Cal Care works, how to enroll and how to get primary providers, etc.

TRANSITION COMMISSION, "B" TASKS: FINANCE

- Continue system cost projections, including costs of needed new infrastructure (capital and human), displaced worker retraining, and unemployment costs.

- Complete modeling of health tax structure. Finalize tax structure.

- Prepare for implementation of FSS-based purchasing policies, including issuance of wholesale distribution competitive bids and retail reimbursement contracts.

- Issue competitive bid for claims submission and processing and payments and other foundational health system tasks.

PHASE TWO/YEAR TWO

"A" TASKS: ADMINISTRATION AND PLANNING

- Health Commissioner elected.

- Health Commissioners, County Health Officers, Consumer Advocates, Director of State Health Agency appointed.

- Transition Commission work reviewed and refined.

"A" TASKS: FINANCE

- Health Fund initiates work, hiring.

- Health system global budget drafted.

- Tax structure reviewed and announced publicly.
- Winner of claims and payment competitive bid selected. Contracts awarded. Work starts.
- Purchasing policies initiated.
- Commission assistance offered, as requested, in employee-employer tax negotiations.

"B" TASKS: ADMINISTRATION AND PLANNING

- State Health Agency and County Health Agency branches established. Hiring and work initiated.
- County Consumer Advocates open offices, hire staff, initiate work.
- Statewide Cal Care education plan initiated.
- Demonstration projects evaluated.
- Enrollment and identification of usual source of care initiated.
- Additional competitive bids initiated, as needed.
- Displaced worker retraining and placement initiated.
- Development of integrated information and data systems continues.
- Target dates set for system implementation.

"B" TASKS: FINANCE

- Provider, facility and integrated systems budgets negotiated
- Final preparation for initiation of tax system, including employer, employee negotiations
- Competitive bids evaluated. Contracts awarded.

PHASE TWO/YEAR THREE, JANUARY 1

SYSTEM IMPLEMENTATION

- Cal Care assumes authority over health system.
- Health tax takes effect.
- Health budgets take effect.
- Health services initiated.

- Information and data systems implemented.
- Purchasing and distribution policies implemented.

TRANSITIONING FROM INSURANCE PREMIUMS TO A HEALTH TAX

The structure of the health tax will be announced early to allow time for tax collection systems to be finalized and for any needed employer and employee negotiations.

Where employers now pay employee insurance premiums they will pay the employee health tax. Where the tax is less than the employer contribution to insurance premiums the return of this value to employees must be negotiated. The State Health Agency will work with unions to assure a smooth transition. Where employees are not represented or where employers do not now offer health benefits, the State Health Agency will assist employer and employee negotiations. For self-employed persons, the tax will be collected through the income tax system.

The Health Fund will work closely with businesses to assure a smooth transition to the alcohol, tobacco and sales health taxes. The Health Fund will collaborate with appropriate state agencies to implement systems or regulations needed to assure deposit of all health monies into the Health Fund.

OBSTACLES TO IMPLEMENTING A SINGLE PAYER SYSTEM

LEGAL OBSTACLES

The following are the major legal obstacles to implementing Cal Care:

- **ERISA.** Hastings Law School has provided an updated analysis of the ERISA exemption as it applies to state health reform. (See Appendix G.) The issue is whether a state can regulate a retirement plan established under federal law, specifically plans established by employers under federal law. In general, the ERISA pre-emption problem has diminished for those wishing to implement a single payer system. The U.S. Supreme Court recognized in Blue Cross v. Travelers Insurance that states have a responsibility to provide for the welfare of their citizens and that the ERISA clause has been interpreted so broadly that it has infringed on legitimate state rights. In recent years circuit courts have also retreated from earlier expansive ERISA interpretations.

- **Independent Review.** Independent Review may be important in a single payer system, especially a fledgling system, because it gives beneficiaries a sense of protection against arbitrary action on the part of the state. Some believe it prevents malpractice litigation and is a substitute for lawsuits. Almost all HMO reform legislation provides for Independent Review and almost every state has such a system in place or in the works. Appendix G contains our own analysis of the issue of preemption of Independent Review.

- **Regulatory Reform.** There is broad agreement that changes are needed in the regulation of our health care system. Contemplated changes must take into account that many regulatory agencies are established by state and federal law. There will be limitations on changes that can be made where federal law applies and "clean up" legislation required where state statute is involved.

- **Commerce Clause.** The Commerce Clause that regulates interstate trade should not be an impediment to implementing Cal Care purchasing policies for three reasons. One, states may regulate commerce within their own borders. Two, states may act on behalf of the welfare of their citizens. Three, there is legal precedent for the concepts we have recommended. It may be prudent to discuss what the state of California is willing to pay for a product rather than to discuss price setting. For example, California will pay Federal Supply Schedule (FSS) prices for pharmaceuticals.

- **Existing Codes.** Proposition 186 held up to Legislative Analyst Office and proposal opponent scrutiny. While some codes have changed, our approach is to include in Cal Care those codes that were in Prop. 186.

- **Retirement Funds**. Folding in retirement funds will have to be negotiated. These funds are vested benefits established by contract. We believe that retirees and those negotiating on their behalf and will prefer to be in the Cal Care system because the coverage will be less expensive, the benefit package more inclusive, and they can get out of the business of negotiating contracts.

- **Regional Differences in Reimbursement Rates.** There should be no legal obstacle as long differences are not arbitrary and a rationale for the differences is put forward.

- **Loss of employment.** We expect no legal impediment to consolidating administrative services, but counsel recommends that funds be set aside for retraining and that every effort be made to utilize existing capacity where feasible.

- **Legislative Challenges.** It may be advantageous to introduce the Cal Care statute through a ballot initiative. This approach better protects the Act from hostile challenges. Also, ballot initiatives require a majority vote, whereas legislative tax measures require 2/3-approval. Article III, Section 10 of the California Constitution blocks the Legislature's ability to change a statute enacted through a ballot initiative. However, any initiative must expressly include a legislative role to amend and alter the statute in the following way: amend with a 2/3-vote and amend only to further intent of the Act.

- **Coordination with Other Laws.** Intent language (from Prop. 186) should be included to provide interpretive benchmarks for any legal challenge.

- **Folding in Federal Funds - Medicare.** Medicare allows state participation in its administration only as it relates to licensing and quality of care. Legislation will be needed to transfer funding and administration. However, it may not be necessary to seek new federal legislation to incorporate Medicare beneficiaries. Cal Care could qualify as a Medicare +Choice HMO under federal law (USC 42 1395w-25). Nothing in federal law prohibits a state from operating a Medicare +Choice HMO. The legislation would have to declare California qualified under the Knox-Keane Act (Health and Safety Code 1341) or authorize it to apply for Knox-Keane status and apply to HCFA to become a Medicare HMO.

- **Folding in Federal Funds - Medicaid (Medi-Cal).** California qualifies for Medicaid funding under USC 42 1396(a). Federal law requires that Medicaid be administered by a single state agency (now DHS). Under Cal Care, authority would be transferred to the State Health Agency. Under current federal law, modifications California would make in its Medi-Cal program would require waivers under 42 USC1315 or 1320a-9. On October 10, long awaited waiver relief was announced by Tommy Thompson that we expect will cover the changes contemplated by Cal Care.

- **Folding in Federal Funds - Federal Employees Health Benefits Program.** Federal legislation almost certainly will be needed to fold in this program. It is unlikely that Congress would abrogate benefit packages that were the result of collective bargaining. Our approach may be to wait until contracts expire and then negotiate their participation in Cal Care.

- **Folding in Federal Funds - Indian Services.** Medicaid pays most of the cost for Indian Health services and these payments are calculated separately. (42 USC 1396). This money may well be subject to Medicaid waivers and may be covered by the October 10 waiver relief.

- **Health Insurance and Portability and Accountability Act of 1996.** This Act imposes stringent data gathering and confidentiality requirements on all health insurers and many

providers. The Cal Care Act must bring our system into compliance. OSHPD currently is working on the impact of this legislation as it impacts hospital care. Portability issues will have to be reviewed. There should be no problem within California, but until there is a national health plan, there could be issues for travelers into and out of the state.

- **Emergency Medical Treatment and Active Labor Act of 1986.** Cal Care will cover care provided in emergency rooms, as required by EMTALA.

- **"State Action" Exemption.** Activities carried out by a state or, under defined circumstances, mandated by a state and carried out by private parties may be exempt from federal and state antitrust laws. Care must be taken to make sure that any proposed legislation or initiative is covered by this exemption.

- **Workers' Compensation.** Cal Care will assume responsibility for the financing and care of injuries and illnesses sustained on the job. Workers' Compensation and the tort system will determine responsibility for lost wages and other costs.

- **Federally Mandated School Health Programs.** According an HHS report, 13% of the nation's school children did not seek care for a one-year period in 1999.[47] Research shows that school clinics are used for primary care and take pressure off emergency rooms. For these and other reasons and because of federal mandates, school clinics will be funded under Cal Care.

- **Regulating Medical School Enrollment and Medical Residency Slots.** Should this be deemed a valuable planning tool in achieving public health goals, it should be possible legally, especially with state funded schools. Finance incentives and political pressure might convince private schools to cooperate with statewide planning efforts. Where state funds support private schools to any extent, exerting pressure is facilitated.

- **Long Term Care.** The two-year waiting period to qualify for long-term care could face a constitutional challenge on the grounds that it inhibits freedom of movement. Cal Care will adjust the requirement if necessary.

- **Extending Benefits to Undocumented and Temporary Residents.** Prop. 187, restricting eligibility for certain health programs, was ruled unconstitutional (League of United Latin American Citizens v. Wilson). The 1996 welfare reform law requires state and local governments to re-enact legislation that provides public benefits, including health coverage to undocumented immigrants. Under federal law, the only persons prohibited from establishing residency are non-immigrants (tourists, those with permanent residences elsewhere, exchange visitors, and business visitors). Everyone else is presumed eligible to establish residency. California courts have found that undocumented immigrants can establish residence for state law purposes.

POLITICAL OBSTACLES

Several issues pose a challenge to single payer advocates. For example, some who oppose single payer believe that it is neither necessary nor desirable for government to be involved in health care. This attitude is not surprising given the long history of market-driven health care in the United States and efforts by the industry to convince us that "socialized" medicine is a bad idea.

In fact, Cal Care retains those elements of the market system that work. The government steps in where the market system has failed. For example, Cal Care retains competition based on quality but restructures administration, which now eats up 20%-30% of our health care dollars. Cal Care includes public-private partnerships for health, which take advantage of business expertise and infrastructure and offer lucrative business opportunities but restructures health financing that now leaves 7 million Californians uninsured. Cal Care does not propose socialized medicine where the government owns health care facilities and trains and employs the health care workforce. Cal Care is a publicly funded, private health care system.

Even in a country where there is suspicion of government, some of our most popular health programs are government programs. Medicare, Veteran's Health Programs, Workers' Compensation and school nurse programs enjoy broad acceptance. We haven't found anyone who worries about turning 65 and getting Medicare, or who complains about accepting veteran's or workplace injury benefits or having a nurse present in the schools.

Other government programs such as MediCal and Healthy Families do not fare as well. What makes a government program work?

In the popular programs participation is automatic, continuous, secure, universal for the group, without social stigma or means testing, provider participation is widespread and

reimbursement is adequate and annual funding assured. In contrast, the less popular programs have complex eligibility and enrollment rules, recurrent means testing, periodic disenrollment when eligibility lapses, social stigma attached to participation, generally unstable financing with poor provider participation with dismal reimbursement. When you look closely, it is not government participation per se that is the problem. It is the nature of the program that makes the difference.

Another potential obstacle to single payer is negative reaction U.S. businesses may have. We believe the Cal Care single payer system will be good for business. Cal Care includes a strong, lucrative role for California businesses. The health care market is expanded by seven million consumers. Public-private partnerships offer many opportunities. The state contributes funding for research and innovation. Business has a seat at the health planning table. Inflation is controlled. The playing field is leveled by making contributions to health an operating expense for all businesses.

Unions are concerned that hard won benefits could be lost. Cal Care guarantees that no Californian will lose any health benefits they now have and that prevailing wages and working conditions will be a contractual requirement for public-private health partnerships.

Ultimately, health system reform will depend on public perception of the need for reform and on a political movement that can translate public desire into political will. Perhaps the greatest obstacle to universal health reform is the division among those who desire it. There are literally thousands of groups and individuals seeking incremental reforms that offer much-needed relief. They are competing for a piece of the pie that is too small to meet everyone's needs, too small to offer everyone relief. If competition would give way to cooperation, it would be possible to build a powerful health rights movement that could win health reform that meets everyone's needs.

AFTERWARD

Ironically, the September 11 tragedy may advance health reform. As we struggle to respond to that dark day we are reminded that some problems are only solved with government involvement.

It became clear early after the attacks that health coverage was a major concern for all touched by the tragedy. There was near universal agreement that the government had to step in and assure that all victims and their families had health coverage. Yet the needs of the September 11 victims mirror those of all Americans. We can all get sick or have an accident, we can all lose a source of support, we can all lose a job, we can all lose loved ones, we can all die suddenly and leave loved ones behind. We can all be touched by tragedy. Health security for all Americans would be a worthy response to September 11.

SOURCES AND USES OF FUNDS UNDER CAL CARE IN 2002

Lewin Group Estimates

(In millions)

Uses of Funds		Sources of Funds	
Benefits Payments at Current Reimbursement Rates Acute Care $131,296 Nursing Home Care $7,367[a/] Home Health Care $3,036[a/] Other Institutionalized $5,435 Alternative Medicine $1,119	$148,253	**Medicare**	$27,124
Bulk Purchasing Savings Prescription Drugs $3,641 Durable Medical Equipment $391	($4,032)	**Champus/Military**	$3,314
Adjustments to Provider Payment Rates Allowance for Reduced Cost Shifting $4,411 Hospital Administrative Savings $2,270 Physician Administrative Savings $5,160	($11,841)	**Medi-Cal/Healthy Families** State Share $10,913 Federal Share $12,897	$23,810
Program Administration	$2,393	**Workers Compensation**	$2,501
Total Spending Before Spending Cap	$134,773	**Safety-Net Savings**	$3,500
Spending Cap Provider Payment Reductions	N/A	**Other State Programs** Developmentally Disabled $2,700 Department of Mental Health $2,100 Department of Alcohol and Drug Abuse $635	$5,435
Total with Spending Cap	$134,773	**Total Intergovernmental Transfers**	**$65,684**
		New Revenues	
		Payroll Tax Employer Share (6.1%) Employee Share (3.6%)	$61,432
		Increase Tobacco Tax ($1.00 per pack) **Increase Sales tax (1/4-cent increase)** **Increased Alcohol tax (eight fold increase)**	$1,011 $1,000 $2,000
		Unearned Income Tax to Fund Remainder Wage Effect Revenue Loss ($151) Tax on Non-earnings Income (2.8%) $3,797	$3,646
		Total New Revenues	**$69,089**
Total Program	**$134,773**	**Total Sources of Funds**	**$134,773**

[a/] Includes cost of maintaining benefits for Medi-Cal eligible persons.

N/A- Not required to stay within global budget cap.

Source: Lewin Group estimates

IMPACT ON HEALTH CARE QUALITY UNDER CAL CARE

Based on Report by AZA Consulting

EXPANDED BENEFIT PACKAGES

COMPREHENSIVE DENTAL/ORAL HEALTH CARE PLAN

Lynn Blair Wood, RDH, BA
Edited by Robert Isman, DDS, Michelle Hurlbutt, RDH, Marsha Larrabee RDH

SCOPE OF DENTAL BENEFITS

A. The basic scope of benefits offered shall include all of the benefits and services listed in this section. Unless specifically stated otherwise, there are no age restrictions.
B. The covered dental benefits/services are limited to the most appropriate restorative or preventive dental treatment option to obtain optimal oral health. If a more costly, optional alternative is chosen by the client, the client will be responsible for all charges in excess of the most appropriate restorative or preventive benefit offered.
C. All dental and preventive services and treatments may be provided by a practitioner acting within the scope of his/her licensure.

DIAGNOSTIC AND PREVENTIVE BENEFITS

A. Initial and periodic oral examinations. Oral examinations are limited to twice in any consecutive 12-month period.
B. Consultations, including specialist consultations
C. Roentgenology, limited as follows:
    (1) Bitewing x-rays in conjunction with periodic examinations are limited to bitewings, one series of four films, in any 12 consecutive month period. Isolated bitewing or peri-apical films are allowed on an emergency or episodic basis.
    (2) Full mouth x-rays in conjunction with periodic examinations are limited to once in a 2-year period, unless a need is shown.
    (3) Panoramic film x-rays are limited to once in a 3-year period.
D. Prophylaxis services, limited as follows:
    (1) Not to exceed two in a 12-month period
    (2) A third and/or fourth prophylaxis may be provided as a benefit for high-risk clients in the following categories:
        a. Women who are pregnant.
        b. Clients undergoing cancer chemotherapy.
        c. Clients with compromising systemic diseases, such as diabetes, determined to be medically necessary for appropriate dental/preventive care by the provider.
        d. Clients who are developmentally disabled.
    (3) Periodontal maintenance prophylaxis services, limited as follows:
        a. Not to exceed four in a 12-month period.
        b. Clients must have been previously treated periodontally with surgery and/or root planning.
        c. Only four prophylaxis or periodontal maintenance prophylaxis or combination thereof, in a concurrent 12-month period.

E. Topical fluoride treatment
    (1) Gels and foams, up to once every 6 months.
    (2) Fluoride varnish, up to 3 times per year.
F. Dental sealant treatments for children up to and including 18 years of age, limited as follows:
    (1) Permanent first, second and third molars, permanent bicuspids, lingual pits of permanent incisors, and primary first and second molars.
G. Space maintainers, including removable acrylic and fixed band type.
H. Preventive dental education and oral hygiene instructions.
I. Diagnostic tests, including pulp vitality tests, bacteriologic studies for determination of pathologic agents, diagnostic models, and caries susceptibility tests (of saliva).
J. Provision/prescription and/or dispensing of fluoride supplements to patients residing in non-fluoridated communities.

RESTORATIVE DENTISTRY (RESTORING CARIES/CAVITIES)

A. Restorations, limited as follows:
    (1) Amalgam, composite resin, micro filled resin, glass ionomer, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.
B. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.
C. Use of pins and pin build-up in conjunction with a restoration.
D. Sedative base and sedative fillings.

ENDODONTICS (TREATMENT OF THE PULP)

A. Direct pulp capping.
B. Pulpotomy and vital pulpotomy.
C. Apexification filling with calcium hydroxide.
D. Root amputation.
E. Root canal therapy, including culture canal, limited as follows:
    (1) Retreatment of root canals if clinical or radiographic signs of abscess formation are present, and/or the client is experiencing symptoms.
    (2) Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, if pathology is present.
F. Apicoectomy.

PERIODONTICS (TREATMENT OF GUMS AND BONES THAT SUPPORT THE TEETH)

A. Emergency treatment, including treatment for periodontal abscess and acute periodontitis.
B. Periodontal scaling and root planning, and sub-gingival curettage, limited as follows:
    (1) Five quadrant treatments in any 12 consecutive months.
    (2) Supported by documentation with periodontal probing measurements.
C. Periodontal maintenance prophylaxis services, limited as follows:
    (1) Not to exceed four in a 12-month period.

(2) Clients must have been previously treated periodontally with surgery and/or root planing

D. Prophylaxis that is included in a periodontal procedure is subject to the same limitations as other prophylaxis (Section 2. D.) and/or periodontal maintenance prophylaxis.
E. Only four prophylaxis or periodontal maintenance prophylaxis or combination thereof, in a concurrent 12-month period.
F. Gingivectomy.
G. Osseous or muco-gingival surgery.
    (1) Placement of locally delivered antibiotic/antimicrobials up to twenty-one sites in a calendar year.
    (2) Prescriptions for antibiotics/antimicrobials or other medications to treat periodontal disease.

CROWNS, JACKETS, CAST AND FIXED BRIDGES

A. Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:
    (1) Replacement of each unit is limited to once every 5 years, except when the crown is no longer functional as determined by the dentist.
    (2) Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
    (3) Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that a filling will not hold.
    (4) Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
B. Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:
    (1) Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment, and the cost difference between a partial and a fixed bridge will be paid by the client.
    (2) A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth if the client is 16 years of age or more and the client's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a client under the age of 16, the client must pay the difference in cost between a space maintainer (partial) and a fixed bridge.
    (3) Fixed bridges used to replace missing posterior teeth are considered optional when both abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
    (4) Fixed bridges are optional when provided in connection with a partial denture on the same arch.

(5) Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

C. The benefit plan allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.
D. Recementation of crowns, bridges, inlays and onlays.
E. Cast post and core, including cast retention under crowns.
F. Repair or replacement of crowns, abutments or pontics.

REMOVABLE PROSTHETICS (DENTURES AND PARTIAL DENTURES)

A. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:
    (1) Partial dentures are not to be replaced within 5 years unless:
        (a) it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
        (b) it is determined that there has been such an extensive loss of remaining teeth, or a change in supporting tissue, that the existing appliance cannot be made satisfactory.
        (c) the denture is unsatisfactory and cannot be made satisfactory.
B. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the client and the dentist, and is not necessary to satisfactorily restore an arch, the client will be responsible for all additional charges.
C. Removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional and the client will pay the additional charges.
D. Full upper and/or lower dentures are not to be replaced within 5 years unless:
    (1) the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
    (2) it is determined that there has been such an extensive loss of remaining teeth, or a change in supporting tissue, that the existing appliance cannot be made satisfactory.
E. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. The benefit paid will be the applicable percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance.
    (1) If a more personalized or specialized treatment is chosen by the client and the dentist, the client will be responsible for all additional charges.
F. Office or laboratory relines or rebases, limited to one per arch in any 12 consecutive months.
G. Denture repair.
H. Denture adjustment.
I. Tissue conditioning, limited to two per denture or partial denture.
J. Denture duplication.
K. Implants - appliances inserted into bone or soft tissue in the jaw:
    (1) to anchor a denture.
    (2) to replace a single tooth where a partial or bridge is not appropriate as determined by the dentist.

L. Stayplates, limited as follows:
    (1) Stayplates are a benefit only when used as anterior space maintainers for children.
    (2) To replace extracted anterior and/or bicuspid teeth for adults during a healing period.

ORAL SURGERY (EXTRACTIONS, OTHER PROCEDURES, PRE- AND POST-OPERATIVE CARE)

A. Extractions, including surgical extractions.
B. Surgical removal of impacted teeth, limited to:
    (1) when evidence of pathology exists.
    (2) if impacted teeth are or will cause damage to other teeth.
C. Biopsy of oral tissues
D. Alveolectomies
E. Excision of cysts and neoplasms
F. Treatment of palatal torus
G. Treatment of mandibular torus
H. Frenectomy
I. Incision and drainage of abscesses
J. Post-operative services including exams, suture removal and treatment of complications
K. Root recovery (separate procedure)

ORTHODONTIC TREATMENT

A. Medically necessary orthodontia
B. Functionally necessary orthodontia

OTHER DENTAL BENEFITS

A. Local anesthetics
B. Oral sedatives when dispensed by a practitioner acting within the scope of his/her licensure.
C. Nitrous oxide when administered by a practitioner acting within the scope of his/her licensure.
D. Emergency treatment, palliative treatment.
E. Hospitalization or out-patient surgery setting, including general anesthetic, when medically appropriate, necessary or essential to the delivery of dental services.
F. Major surgery for fractures and dislocations of oral structures.
G. Loss or theft of dentures or bridgework
    (1) Only once within 5 years.
H. Treatment of Malignancies.
I. The cost of precious metals used in any form of dental benefits.
J. The removal of implants.
K. Behavior management, when medically appropriate.
L. Prescription antibiotics and analgesics when dispensed by a practitioner acting within the scope of his/her licensure.
M. Oral health services that are usual and customary but not specifically listed as a benefit.

MEDICAL BENEFITS FOR A DISABILITY-SENSITIVE HEALTH CARE SYSTEM

Prepared by Laura Remson Mitchell

1. Prescription Drugs and biologicals, including injectables and bio-engineered treatments.

2. Durable Medical Equipment and Assistive Technology, including repair devices based on MediCal's revised definition (R-5-99E, as amended 9/25/00).

3. Rehabilitation Therapy, including physical, occupational, speech and cognitive therapies, in hospitals and clinics. No limits on number or days of treatments when ordered by overseeing provider as part of a health maintenance and prevention program.

4. Access to specialty care providers.

5. Orthotics and prosthetics

6. Information and functional training for one's specific disability.

7. Accessible transportation.

8. Home Care, by professional type prescribed by covering provider.

9. Long Term Care services, home and community-based, using IHSS "social service" model rather than the MediCal model.

10. Reimbursement for family members or friends rendering personal care services prescribed by a primary provider.

11. All other services provided to non-disabled persons.

EXPANDED LONG TERM CARE BENEFITS (LTC)

Long term care services are defined as those health, social, housing transportation and other supportive services needed by persons with physical, mental or cognitive limitation sufficient to compromise independent living. Recent estimates by Charlene Harrington, RN, Ph.D, Professor, University of California, San Francisco, demonstrate that the state of California could provide rich LTC benefits to the entire population for $4.9 billion (in 1998 dollars).

1. **Initial**: Cal Care LTC benefits will be covered to the extent currently provided to Medicare and Medicaid beneficiaries and in the large group Kaiser Permanente benefit package.

2. **Expanded**: Cal Care LTC Benefits include: All Medicaid LTC benefits, personal care services (currently under IHSS program), all LTC covered under Department of Disability and Mental Health programs, meals and other LTC programs under DHS and DOA programs and LTC services provided by the Centers for Independent Living and other special LTC programs in California.

3. **Coordination**: LTC benefits will be coordinated with acute and outpatient services and will emphasize functional independence, will eliminate bias toward institutional care and encourage community-based support.

4. **Quality Initiatives**:
    a. Uniform, enforceable standards of care and quality assurance under a single regulatory authority with power to decertify institutions and licensed individual providers.
    b. Education, continuing education and licensing standards for all formal LTC providers.
    c. Wage parity for LTC works with hospital workers.
    d. Data bases to support outcome measurement and monitoring of providers.
    e. Accessible consumer information about LTC providers and facilities, including quality indicators, education and training, ownerships, financial profile.
    f. Education track for long term care physician, PA and FNP specialists.
    g. Criminal background checks for all formal LTC providers.

REFERENCES AND ENDNOTES

[1] The World Health Report 2000 - Health systems: Improving performance. Accessed on the web 01-Oct-01 at http://www.who.int/whr/2000/en/report.htm

[2] HRSA State Health Workforce Profiles: California. Accessed 21-Sep-01 at ftp://ftp.hrsa.gov//bhpr/workforceprofiles/ca.pdf.

[3] Brown ER, Meng YY, Mendez CA, Yu H. Uninsured Californians in Congressional Districts, 2000. UCLA Center for Health Policy Research, June 2001. Accessed 30-Sep-01 on web at: http://www.healthpolicy.ucla.edu/UninsuredCaliforniansInCongressionalDistricts.html

[4] Schauffler HH; McMenamin S; Cubanski J; Brown ER; Rice T. The State of Health Insurance in California, 1998. University of California, Berkeley, Center for Health and Public Policy Studies and the University of California Los Angeles, Center for Health Policy Research. January 1999.

[5] Community Health Status Report. HRSA, USDHS. Available at http://www.communityhealth.hrsa.gov

[6] Remy LL, Oliva G, Clay T. The Longitudinal Impact of Medicaid and Managed Care Expansions in California on Child and Adolescent Hospital Access and Outcomes 1983 to 1998. Family Health Outcomes Project, UCSF. APHA, October 2001.

[7] Report finds 'Service Gaps" in State's trauma centers. California Healthline. 24-Jan-01.

[8] Zach AP, Romano PS, Luft HS. Report on Heart Attack, 1991-1993, Volume One: User's Guide. Sacramento, CA: Office of Statewide Health Planning and Development. December 1997. Available at http://www.oshpd.cahwnet.gov/hpp/chop/volume1ami.pdf

[9] Damberg CL, Chung RE, Steimle I. The California Report on Coronary Artery Bypass Graft (CABG) Surgery. Summary Report for 1997-1998 Hospital Data. San Francisco CA: Pacific Business Group on Health and the Office of Statewide Health Planning and Development. July 2001.

[10] All Medicare HMOs are NOT alike: Guide to California Medicare HMOs. California HealthCare Foundation and Consumers Union. Available online at http://www.consumerreports.org.

[11] Prescription drug expenditures in 2000: The upward trend continues. A report by the National Institute for Health Care Management Research and Education Foundation. Available on the web at: http://www.nihcm.org.

[12] Testimony of George F. Grob, Deputy Inspector General for Evaluations and Inspections, before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations on Medicare Payments for Prescription Drugs. September 21, 2001. Office of Inspector General, U.S. Department of Health and Human Services. Accessed on the web 01-Oct-01 at: http://www.hhs.gov/oig/testimony/2001/092101grob.htm

[13] For the current list of Corporate Integrity Agreements, see: http://www.dhhs.gov/progorg/oig/cia/ciacurrent.htm. Examples of California CIAs between the Office of the Inspector General, Department of Health and Human Services include: Guardian Post-Acute Services, Inc., http://www.dhhs.gov/progorg/oig/cia/agreements/guardian_post_acute_serv_06092000.pdf, Napa County, http://www.dhhs.gov/progorg/oig/cia/agreements/napa_co_041700.pdf. California Emergency Physicians Group, http://www.dhhs.gov/progorg/oig/cia/agreements/ca_emerg_phy_grp_072500.pdf. Central Coast Emergency Physicians, http://www.dhhs.gov/progorg/oig/cia/agreements/central_coast_emerg_phys_020501.pdf

[14] Department of Consumer Affairs: Lengthy delays and poor monitoring weaken consumer protection. California State Auditor. November 2000 (2000-111) Available at http://www.bsa.ca.gov/bsa.

[15] Results of the Audit of Investment Income Earned by Managed Care Organizations with Risk-Based Contracts (A-02-98-01005 - August 18, 2000. Accessed on 02-Oct-01 at: http://www.hhs.gov/progorg/oas/reports/region2/29801005.htm

[16] TAP's $875 million settlement now official. Modern Healthcare, 04-Oct-01. Accessed at http://www.modernhealthcare.com/news_briefs.php3?action=view&id=2277

[17] HCFA Extended its contract with accounting firm implicated in major fraud. GAO-01-136R. Released 31-Oct-2000. Available on the web at: http://www.gao.gov/

[18] Nonprofit hospitals: Better standards needed for tax exemption. GAO. May 1990. Available at http://161.203.16.4/d24t8/141681.pdf

[19] California HMO Report Card. Department of Managed Health Care, California Business, Transportation and Housing Agency. Available at: http://wp.dmhc.ca.gov/report_card/HealthPlanPerformanceResults.asp

[20] Kohn LT, Corrigan JM, Donaldson MS (eds). To Err is Human: Building a Safer Health System. A report from the Committee on Quality of Healthcare in America, Institute of Medicine, National Academy of Sciences. National Academy Press, Washington, DC, 1999.

[21] America's Health in Transition: Protecting and Improving Quality.: Institute of Medicine Report Washington, DC: National Academy Press. 1994.

[22] Kaushal R, Bates DW, Landrigan C, McKenna KJ, Clapp MD, Federico Fk, Goldmann DA. Medication errors and adverse drug events in pediatric inpatients. JAMA. 25-Apr-01. 2114-2120.

[23] See for example, http://www.healthgrades.com.

[24] Luft HS, Romano PS, Remy LL. Annual Report of the California Hospital Outcomes Project. Volume One: Study Overview and Results Summary, Acute Myocardial Infarction. Sacramento, CA: Office of Statewide Health Planning and Development. May 1996.

[25] Burstin HR, Lipsitz SR, Udvarhelyi IS, Brennan TA. The effect of hospital financial characteristics on quality of care. JAMA 1993 Aug 18, 270(7):845-9.

[26] Thomas, EJ, Orav, EJ, Brennan, TA. Hospital ownership and preventable adverse events. J. Gen Intern Med 2000;15:211-219.

[27] Burstin HR, Lipsitz SR, Udvarhelyi IS, Brennan TA. The effect of hospital financial characteristics on quality of care. JAMA 1993 Aug 18, 270(7):845-9.

[28] Ashton CM, Kuykendall, DH, Johnson ML, Wray NP, WU L. The association between the quality of patient care and early readmission. Annals of Internal Medicine. 122(6), 415-421.

[29] Hand R, Sener S, Imperato J, Chmiel JS, Sylverster J, Fremgen A. Hospital variables associated with quality of care for breast cancer patients. JAMA, Dec. 25, 1991. 266(24): 3429-3432.

[30] Braveman PA, Egerter S, Bennett T, Showstack J. Differences in hospital resource allocation among sick newborns according to insurance coverage. JAMA, Dec. 18, 1991. 266(23): 3300-3308.

[31] Nursing home staffing levels are inadequate in the 13th Congressional District of California. Special Investigations Division, Committee on Government Reform, U. S. House of Representatives. December 7, 2000. Available at http://www.house.gov/stark/documents/106th/CA13nursingreport.pdf

[32] American Nurses Association. (1997). Implementing Nursing's Report Card. A Study of RN Staffing, Length of Stay and Patient Outcomes. Washington, DC: American Nurses Publishing.

[33] Kovner C, Gergen P. Nurse staffing levels and adverse events following surgery in U. S. hospitals. Journal of Nursing Scholarship. 1999, 30:315-21.

[34] Needleman J, Buerhaus PI, Mattke S, Stewart M, Zelevinsky K. Nurse staffing and patient outcomes in hospitals. Final Report for Health Resources Services Administration Contract No. 230-99-0021. February 28, 2001.

[35] Bond, CA, Raehl, CL, Pitterle, ME, Franke, T. Pharmacotherapy, 1999 Feb, 19(2):130-8.

[36] Bond CA, Raehl CL, Franke T. Clinical pharmacy services and hospital mortality rates. *Pharmacotherapy*, 1999 May, 19(5):556-64.

[37] Report to the President on Transforming Health Care Through Information Technology, February 9, 2001, President's Information Technology Advisory Committee, National Coordination Office for Information Technology Research and Development

[38] MMCD Letters 99-01-99005

[39] National Immigration Forum, "Facts on Immigration and the Economy." January 2000

[40] Personal Communication. Ignatius Bau, Deputy Policy Director, Asian and Pacific Islander Health Forum, Oct 2001.

[41] 64 Federal Register 28676-88, 26 May, 1999

[42] Testimony of Alan Sager before the Sub-committee on Consumer Affairs, Foreign Commerce and Tourism, Committee on Commerce, Science, and Transportation, U.S. Senate. Americans would save $38 billion in 2001 if we paid Canadian prices for brand name prescription drugs. Wednesday 5 Sep 2001.

[43] Sager A, Socolar D. A prescription drug peace treaty. Pre-Publication copy. Health Reform Program, Boston University School of Public Health, Tentative release date Thursday 5 Oct 2000.

[44] Newhouse JP and The Insurance Experiment Group. Free for All? Lessons from the RAND Health Insurance Experiment. Cambridge: Harvard University Press, 1993.

[45] Assumes average per capita spending for under 65 of $3570 or 78% of the average expenditure. Assumes uninsured persons lack 40% of needed cares, ie we are now paying for 60% of their needed care. Assumes42 million uninsured under age 65. So: 0.78x $4680 x 0.40 x 42 million=$61b) This study will reveal the extent of savings attainable in California

[46] Reid R, MacWilliam L, Roos NP, Bogdanovic B, Black CC. Measuring morbidity in population performance of the Johns Hopkins Adjusted Clinical Group (ACG) case-mix adjustment system in Manitoba. Manitoba Centre for Health Policy and Evaluation, June 1999.

[4747] Personal Communication. Stanton Price, Attorney, October, 2001

CAL CARE APPENDICES

NOTE: The Appendices can be accessed through
the California Health and Human Services Agency

APPENDIX A: QUALITY FIRST

Table 1: California Healthcare Infrastructure Indicators per 100,000 population
Table 2: Variation in Community Health Status
Cultural Linguistic Considerations -- Beatriz Solis, M.P.H.
AB 394 The Registered Nurse Staff Ratio Law and related materials
Health Insurance Commission of Australia--Charter of Care
Health Planning -- Margot W. Smith Ph.D.
Guide to the Delineation of Medical Care Regions, Medical Trade Areas, and Hospital Service Areas. -- Margot W. Smith Ph.D.
California Map of Medical Service Areas
Cal Care Recommendations for Quality Long Term Care
Value of an Integrated Health Care System- Judy Spelman, RN

APPENDIX B: GOVERNANCE

California State Agencies Involved in Health Care
California State Government Offices
OSHPD- Mission and Organizational Structure
California Health and Human Services Department- Mission and Organizational Structure
Department of Health Services- Mission, Programs and Organizational Structure
Cal Care Commission Selection and Function (selection from SB 2123 as introduced), and Addendum summarizing campaign finance reform and possible application to election of Commissioner in California (prepared by Anna Thorn, MD), and the Maine campaign reform legislation.
Consumer Advocate: An Alternative View (prepared by John Metz and Irwin Hoff)

APPENDIX C: FINANCE

TABLES

2001-02 Governor's Budget General Fund Budget Survey
2001-02 General Fund Expenditure, State of California
2001-02 General Fund Expenditures by Agency, State of California
2001-02 Expenditures by Fund, State of California
2001-02 Revenue Sources, State of California

PURCHASING POLICIES

"A Prescription Drug Peace Treaty"--Alan Sager, Ph.D., and Deborah Socolar, M.P.H.

"Seven Myths Impeding Prescription Drug Reform in the United States." Alan Sager, Ph.D.

"Americans Would Save $38 billion in 2001 if We Paid Canadian Prices for Brand Name Prescription Drugs"--Testimony of Alan Sager, Ph.D. before the US Senate Subcommittee on Consumer Affairs, Foreign Commerce and Tourism and the Committee on Commerce, Science and Transportation, September 5, 2001

Comparison of Federal Supply Pharmaceutical Prices, Foreign Drug Prices and U.S. Drug Prices

Federal Supply Schedule for Pharmaceuticals

Demonstration of Competitive Bidding Clinical Laboratory Services: Demonstration Plan, Final Report. Prepared by Center for Economic Research for the Health Care Financing Administration, September, 1997

RISK ADJUSTMENT

"Measuring Morbidity in Population: Performance of the Johns Hopkins Adjusted Clinical Group (ACG) Case-Mix Adjustment System in Manitoba." June 1999, Manitoba Centre for Health Policy and Evaluation, University of Manitoba"

MD COST CONSTRAINTS

Continuing Medical Education for Licensure Reregistration in the United States

APPENDIX D: ELIGIBILITY AND ENROLLMENT

Overview of Immigrant Eligibility for Federal Programs, National Immigration Law Center, Summer 2001

California Code 244 Determination of Place of Residence

APPENDIX E: BENEFITS

EXPANDED CAL CARE BENEFIT PACKAGES

Long Term Care
Mental Health Parity
Complementary and Alternative Medicine
    CAM Tables 1-3
    CAM Licensing Requirements
Disability

MENTAL HEALTH PARITY

Foreign Service Benefit Plan-Mental Health and Substance Abuse Benefits
AB 88 Mental Health Parity, Assembly Member Helen Thomson, December, 1998
State of Massachusetts, Senate Bill 2172. Mental Health Parity

COMPLEMENTARY AND ALTERNATIVE MEDICINE

Prevalence and Frequency of Use of Unconventional Therapy Among 1539 Adults
Therapies or Systems Designated as Having a Licensed Practitioner by Number of States
CAM Therapies Covered by Insurers
"Trends in Alternative Medicine Use in the United States, 1990-1997." David M. Eisenberg, M.D., et al
"Why Patients Use Alternative Medicine: Results of a National Study." John A. Astin Ph.D., JAMA, May, 1998
"A Regional Survey of Health Insurance Coverage for Complementary and Alternative Medicine: Current Status and Future Ramifications." Maria B. Cleary-Guida, M.S., et al
"Use of alternative therapies: Estimates from the 1994 Robert Wood Johnson Foundation national access to care survey." L. Clark Paramore, Journal of Pain and Symptom Management, 13(2) Feb. 1997.

LONG TERM CARE

"A National Long-Term Care Program for the United States: A Caring Vision." Charlene Harrington, Ph.D., and the Working Group on Long-Term Care Program Design, Physicians for a National Health Program, JAMA 1991
Program for the All-Inclusive Care for the Elderly (PACE), Fact Sheet, Frequently Asked Questions and California PACE Programs
On Lok Senior Health- Program Description and Member Profile Snapshot
"My Mom, Your Mom: Care of the Elderly Frail." Judy Spelman, R.N., October, 2001
"Germany's Long Term Care Insurance Model: Lessons for the United States." Charlene Harrington Ph.D, Max Geraedts M.D., Geoffrey V. Heller, July 2001
Discussion of Medicaid Services and Title XIX of the Social Security Act, Laura Remson Mitchell

APPENDIX F: THE VIEW FROM ABROAD

"Evolution of the Canadian Health System." Jennifer Dunham, Summer, 2001

APPENDIX G - LEGAL

Independent Review by Stanton Price
"ERISA: Impact on a Single Payer Reform." Provided by Hastings School of Law